

# **Exploring experiences of HIV Counsellors towards the HIV Counselling and Testing Policy in Zambia's Public Urban Health Centers**

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A mini-dissertation submitted to the Faculty of Health Sciences, University of Cape Town, in partial fulfillment of the requirements for the degree of Master of Public Health (Health Systems)

**Cape Town, 2014**

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## DECLARATION

### MPH (Health systems) Mini-Dissertation

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Date:           **14 February 2014**

## **DEDICATION**

This study is dedicated to the hardworking men and women in Zambia who have dedicated their lives to offering HIV counselling in difficult settings while facing numerous challenges

## **ABSTRACT**

The theory of street-level bureaucracy has achieved much acclaim among public policy scholars. It has been used to understand the behaviours of frontline workers and their impact on policy implementation and helps to ensure their accountability throughout policy change. This emanates from the core argument of the theory that laws and policies are not formulated in legislative or higher offices, but that frontline workers who actively distribute services or give sanctions, formulate policies through routines and practices. Their version of policy is reflected in the experiences of citizens. This premise falls in the school of bottom-up theories, which challenges the conception that policy processes occur in a top down and logical manner.

Taking HIV counsellors in Lusaka's urban clinics as a case study, this study sought to understand the behaviours of frontline workers and their role in policy implementation. It used the theory of street-level bureaucracy to explore their experiences and challenges; and initiatives that counsellors developed in order to cope with their work. Despite the fact that HIV Counselling and Testing (HCT) guidelines had been in place for more than 4 years at the point of data collection, counsellors still faced numerous challenges when implementing them. These challenges, which were mostly related to infrastructure and human resource constraints, were seldomly addressed in the context of competing health priorities. The study also explored the concept of 'discretion' and found that due to a lack of organisational expectations and proper performance systems, ignorance of the HIV counselling and testing policies, and infrequent supervision and expectations from their supervisors, HIV counsellors exercised a great deal of discretion. They developed their own routines and set their own expectations for their job performance.

There is a gap in operational research seeking to understand the role of frontline workers in implementing health policies in Zambia. This makes it difficult for policy makers to keep frontline workers accountable for the successes and failures of health policies. There is therefore an urgent need to generate qualitative data that provides insight into the various roles that frontline workers play in policy formulation and implementation. This study explored the challenges and experiences in HCT policy implementation among psychosocial counsellors in urban health clinics in the Lusaka district of Zambia and explained their behaviours using the theory of street-level bureaucracy.

Data was collected by in-depth interviews, from HIV counsellors, facility managers and policy makers, which was coupled with direct observation of health facilities and review of documents. The data was analysed using thematic and interpretive analysis.

This minor dissertation is in four parts. The protocol (Part A) presents the concept note of the study and its methodology. A structured literature review (Part B) provides a background and broadly reviews previous research and findings on the theory and on policy implementation. The journal-ready article is presented in Part C, while Part D presents the study tools and related resources (appendices).

Although most HIV counsellors recognised the importance of the HCT guidelines in providing good quality HIV services, they did not demonstrate any knowledge of what is contained in the guidelines. However, the knowledge they had from their training was in line with the contents of the guidelines. Furthermore, despite their commitment and willingness to abide by the guidelines (be it in the policy or from training) they were faced with significant challenges of infrastructure, human resources and relational problems with other health professionals. These challenges forced them to develop coping mechanisms to offer their services. For instance they introduced

group counselling, reduced the amount of time spent on counselling and in few cases rationed their time based on the seriousness of clients' needs

The study contributes to the school of thought that promotes bottom-up approaches to policy formulation and implementation. It demonstrated that frontline workers, being responsible for policy implementation have the 'power' to change policy in practice.

## **Acknowledgements**

I am grateful to the almighty God for his miraculous guidance, abundant life and the wisdom in balancing my studies with work. I also acknowledge the professional and lay psychosocial counsellors who were receptive to me to conduct the study and volunteered their time despite the busy schedules. I also thank various facility managers, the sisters-in-charge in all the 15 clinics for welcoming me to their facilities and ensuring that I was successful in my data collection. I am also grateful to my research assistant Mr. Isaac Mwaipopo for doing much of the preparatory work and Mr. Gates Banda for assisting with scheduling of site visits for data collection.

I also want to thank University of Cape Town and the Center for International Health at Ludwig-Maximilians-University (CIHLMU) for the financial contribution towards my studies. I am also grateful to my employer Sonke Gender Justice, for the flexibility and understanding while I pursued the degree programme. In particular I thank my two managers Mr. Tim Shand and Ms Itumeleng Komanyane and our Human Resources Manager, Pam Reedy for their moral support and professional guidance.

I would be failing in my duties if I did not acknowledge the contributions and guidance of my two ‘super’ supervisors, Prof. Lucy Gilson and Dr. Erin Stern. Their prompt feedback was very critical for the success of this study.

To my wife Kabaso Kabwe Shawa, I am grateful for your moral, emotional and academic support, for the midnight snacks and coffee. I love you.



## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CDC	Center for Disease Control
DCT	Diagnostic Counselling and Testing
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
VCT	Voluntary Counselling and Testing
LuDHMT	Lusaka District Health Management Team
MCDMCH	Ministry of Community Development, Mother and Child Health
MOH	Ministry of Health
MoFNP	Ministry of Finance and National Planning
NAC	National AIDS Council
PMTCT	Prevention of Mother-To-Child Transmission
SLB	Street-Level Bureaucracy
UNAIDS	United Nations Programme on AIDS
UNFPA	United National Population Fund
WHO	World Health Organisation
ZCC	Zambia Counselling Council

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# **PART A: Protocol**

## **1.0 INTRODUCTION**

Zambia is currently facing a generalised HIV epidemic with an estimated prevalence of 14.3% adults aged from 15-49 (UNAIDS, 2012). The epidemic is also feminised in that there are more females than males living with HIV with an estimated prevalence of 16.1% compared to the prevalence of 12.3% for males (CSO,2009). The Zambia Demographic and Health survey reported that urban areas have a higher prevalence of HIV compared to rural areas with 20 and 10% prevalence rates respectively (CSO,2007). Further, HIV infections are higher in stable relationships such as marriage and cohabitation than the national average, with an estimated prevalence of 16% in marriages and 15% in cohabiting couples (MOH, 2012). While there are a number of behavioural drivers of HIV such as multiple concurrent partnerships and low condom use, adequate knowledge levels of HIV among men and women are still significantly low. According to the HIV surveillance survey of 2009, although more than 90% of the population has heard of HIV, only 36 % had comprehensive knowledge of HIV

Until 2006, Zambia had no comprehensive and standardised HIV counselling and testing (HCT) operations. This was despite the fact that at the time, more than 16% of the population was living with HIV and the government had declared AIDS a national crisis four years earlier (UNAIDS 2006). Indeed, the AIDS response was being managed within the legal framework of an act of parliament of 2002 (MOH, 2006). The Act generated a national awareness of the epidemic and created an increase in demand for both HIV counselling and testing services. In the same vein, there was an increase in facilities that provided these services. For example in 1999, Zambia had only 21 HTC sites and by 2006 there were more than 450 sites across the country (MOH, 2006).

According to the government, in 2006 a multidisciplinary team representing physicians, non-governmental organisations, public health workers, social workers, laboratory experts and counsellors was mobilised to develop HCT guidelines. The team engaged in a consultative process with expert groups including people living with HIV (PLHIV), people with disabilities,

the private sector and other key players in the AIDS response (MOH, 2006). These guidelines were then expected to act as a blueprint for the scaling up of HCT and to help service providers in health to maintain high quality standards of HCT in Zambia. The guidelines were to be followed by service providers in both public and private health facilities. HCT counsellors in Zambia are often responsible for both counselling and testing for HIV using rapid antibody tests that require finger prick blood samples.

Since the introduction of the HCT policy guidelines in Zambia, there has not been any study or research to evaluate their effectiveness or the degree of adherence to the HCT guidelines among service providers. Although this study will not explore the degree of adherence to the HCT policy, it will bring attention to the experiences of the counsellors as a starting point in understanding its effectiveness. In Zambia, there is some research that documented the role of implementers in policy implementation (Crosby, 1996; Gilson et al., 2003; Kalumba, 1997). However, there is no research that has documented the experiences of service providers as they interact with the HCT policy in particular.

### **1.1 Theoretical Framework**

According to Gilson (2011), a theoretical framework provides language and a basis for making inferences. It helps to understand social phenomena and explain why certain things are what they are. A theoretical framework in fixed designs helps to formulate hypotheses, which can then be proven or tested. In flexible research designs, it provides constructs that are not fixed and can help to put the study into context. This study will make use of the theory of Street Level Bureaucrats (SLB) to better understand and describe the experiences of Counsellors in implementing the HIV Counselling and Testing guidelines.

Lipsky's thesis about the dilemmas of the individual in public services, framed in the idea of "street-level bureaucrats" (1980), provides much insight into understanding policy implementation in a number of social scientific fields. One of the key elements of Lipsky's work

is how he portrays front-line workers in public service. He presents their human dilemmas without criticism and brings attention to the difficult work environments or conditions where they implement policy.

One vivid aspect of his discourse on the dilemmas is his description of coping mechanisms, which he presents as responses that front-line workers develop to deal with the challenges they face as a result of inadequate resources, few controls, unrealistic objectives, and demotivating circumstances (ibid.). Haliday et al. (2009:406) summarises Lipsky's coping mechanisms and views them as "three-fold; first, street-level bureaucrats develop patterns of practices—routines and stereotyping—to limit demands on their time and resources; second, they modify the concept of their job to narrow the gap between objectives and resources; third, they modify the concept of their clients to render the inevitable gap between objectives and accomplishments more palatable". These premises have implications on policy implementation including the HCT policy that this study will be looking at. Although the kind of coping mechanisms may differ from one context to another, as well as from one policy to another, it is important that the mechanisms put in place are not detrimental to the objectives or the expected outcome of such a policy.

In order to effectively study the experiences of the HIV counsellors as they implement the HCT policy, it is important to develop some assumptions based on Lipsky's arguments. The first critical and most fundamental assumption is that the Counsellors who work in public service implementing the HCT policy are in fact street-level bureaucrats because they are responsible for implementing policies and are typically the intermediary between the beneficiaries and the policy. Lipsky also depicts front-line workers as having good intentions to serve as they enter public service. Thus the assumption would be that the HIV counsellors enter public service with intention to serve. And lastly, Lipsky sympathized with the challenging environments in which front-line workers work and the coping mechanisms they develop as a result. The assumption therefore is that HIV Counsellors are overwhelmed by their work and demands that they end up



developing coping mechanisms. The study will use the theory of street-level bureaucracy to understand what the experiences and practices of the HIV Counsellors in the selected health centers and how this affects their implementation of the HCT guidelines/policy

## **1.2 Assumptions**

- i. HIV counsellors can be seen as street-level bureaucrats because of the nature of their jobs as front-line public health providers.
- ii. HIV counsellors enter into public service with the intention to serve but the demands and pressures make it difficult for them do their role as expected by policy-makers.
- iii. HIV counsellors are overwhelmed by their work environment and clients such that they end up changing the policy instructions to suit their work environment (coping mechanisms)

## **1.3 Research Question**

What are the experiences of HIV counsellors and how do these experiences affect the implementation of the HIV counselling and testing guidelines in Zambia's urban health centers?

## **1.4 Objectives of the Study**

### **General Objective**

To assess the experiences of HIV counsellors and how their experiences affect the implementation of the HIV counselling and testing guidelines in Zambia's urban public health centers.

### **Specific Objectives**

- i. To document personal stories of why the HIV counsellors entered public service, particularly their current roles as HIV counsellors
- ii. To document the environment in which HIV counsellors work including challenges they face with their workload and their relationships with clients

- iii. To understand how the experiences of HIV counsellors affect their implementation of the HCT guidelines and the coping mechanisms they develop to implement such guidelines?

### **Research Questions**

- i. What motivated/inspired HIV counsellors to enter public service and take up their roles as HIV counsellors?
- ii. What kind of environment do HIV counsellors work in and what challenges do they face in their work as they implement the HCT guidelines
- iii. What measures (including coping mechanisms) have the HIV counsellors put in place to do their work and how do these measures affect the HCT guidelines?

### **1.5 Purpose and Relevance Of The Study**

This is a descriptive case study that seeks to understand how a group of counsellors based in peri-urban primary health clinics experience the implementation of HIV counselling and testing (HCT) guidelines introduced in Zambia in 2006. The study assessed the work environment of the counsellors and how they interacted with the HCT guidelines on a daily basis. The assumption is that in order for them to meet the demands of their work and clients (in public health facilities), the counsellors developed some coping mechanisms. These may range from changing the guidelines to suit the needs around them, to deliberately ignoring some of the guidelines or both. The study will thus investigate what sort of coping mechanisms they developed with in order to implement the stipulated HCT guidelines. As the study is both explorative and descriptive, it seeks to answer the ‘what’ and ‘how’ questions and provide insights around what the street level bureaucrats were doing in reference to the stipulated policy guidelines.

The study also provides insights about what happens with policy in practice. After data analysis, the results will be triangulated with other studies and positioned in the theory of street-level bureaucrats. The objective of this research is not to give a representative or generalizable perspective on front-line work within the health sector, but rather provide an embedded

perspective that is reflective of its context (Yanow, 2000). Although the study will not explain the behaviour of HIV counsellors implementing this HCT policy in the country, it will provide insights into the experiences of those who are interviewed.

## **2.0 PROPOSED METHODOLOGY**

This study design will take a flexible approach for being most pertinent to address the research question, its purpose and the guiding questions. The study rests on qualitative methods to assess how counsellors implement the counselling guidelines for HIV. Typically the study will investigate the phenomenon of inquiry in real life contexts, looking at the street level bureaucrats and their daily interaction with the policy in question. The research design is planned to capture counsellors' understandings of HCT guidelines and other national health policies, as well as their work setting. Because the study will also be investigating counsellors' perspectives and perceptions about policy implementation, multiple data collection methods will be employed. The use of multiple data collection methods will also help to ensure rigour of the study including the accuracy of the data collected.

### **2.1 Study Site**

#### **2.1.1 Choice of Study Site**

The study will be conducted in urban health centers owned by the government in Lusaka Province. The study will be conducted in Lusaka mainly because the province, and specifically the urban areas have the highest HIV rates in the country (CSO, 2009). While HIV is highest in the urbanized province of Lusaka, rural provinces such as the Northern Province have the lowest HIV rates with the prevalence being at 8% for northern and 20.8% for Lusaka (UNAIDS, 2012). The high rates of HIV in Lusaka also justify the need for more HIV counselling and testing services. Consequently, Lusaka has the highest number of HCT services offered in both public and private health facilities (MOH, 2009).

### **2.1.2 Position and Population**

Lusaka is the capital city of Zambia and is the most urbanized province out of the 10 provinces (MOH, 2009). Urban and peri-urban communities that host the urban health centers are often overpopulated with the communities facing a myriad of public health problems. Moreover, the social determinants of health such as poor housing, water and sanitation, poverty also contribute to health-related problems of the population. HIV prevalence is high as a result of various drivers of the epidemic including multiple sexual partners, lower condom use, early sexual debut among young people, lower levels of male circumcision and transactional sex (MOH, 2009). The public health system is strained by many challenges in Lusaka and as a result, most public health interventions including new policies would be first be rolled out in Lusaka.

### **2.2 Research Design**

A descriptive cross-sectional study design using qualitative methods will be employed. The cross-sectional study will investigate the phenomena (experiences of HIV counsellors, the environment in which they work) at one point in time. A descriptive design was selected based on the objectives of the study, all of which are around documenting and presenting the situation as it is and the experiences of the participants in relation to the HCT policy. A cross-sectional study design is the best option considering the limited resources and time available to do the study. As such, an interview guide will be used to get information from participants at one point in time. A qualitative study was chosen because it is the best to elucidate thoughts, perceptions, reflections and experiences of HIV counsellors and those around them regarding the HCT policy.

### **2.3 Sampling Strategy and Data Sources**

The population from which the sample will be selected comprises all government owned urban health centers in Lusaka. Government owned clinics are more likely to provide an environment described by Lipsky in which street level bureaucrats work. Service providers working in these urban health centers have unique experiences and work under unique conditions that qualify them to be viewed as street level bureaucrats. Determining the size of the sample in qualitative

research is often a flexible process, therefore the number of participants in this study will change and increase as new information emerges and or if new informants need to be included to give new information (Marshall, 1996). Once the data being collected reaches saturation levels, whereby no new issues are emerging, the researcher will stop the data collection.

There are a total of 28 urban health centers owned by the Government of the Republic of Zambia. If each center has at least one counsellor, then the population comprises not less than 28 HIV counsellors. The study shall include a convenient sample of at least one counsellor from each of the 28 urban health centers. The counsellors will give the researcher insight into how they are implementing the HCT policy, challenges they face, what they have to do to cope, etc. In addition a convenient sample of 10 facilities will be selected and 10 facility managers will be interviewed. The facility managers will be helpful in describing the environments in which the counsellors work. These counsellors will be sampled purposively based on (i) their experience being at the particular facility and their self-reported familiarity with the facility; and (ii) their presupposed knowledge of the HCT policy guidelines.

At the policy makers level, a convenient sample of 5 staff at the Lusaka District Health Team (LuDHMT) will be included in the study. The staff will be sampled based on their knowledge of the HCT policy and the implementation plan if available. Those with experience of the policy formulation process of that policy will be prioritized. The staff will be important for the study because they will give an overview of the government's expectations of the counsellors and their perceptions on how the HCT policy is being implemented. This will also be an opportunity for them to express some of their policy monitoring challenges and needs for future research areas.

Other sources of data will be secondary sources such as documents. The researcher will study documents that might be referred to during interviews with participants. Also the researcher will use a diary or research journal to record his reflections as he collects data. The journal will be useful at data analysis and interpretation.

## **2.4 Data collection Methods**

Data will be collected using in-depth interviews, key informant interviews, observation, document reviews and journal writing. The in-depth interviews will be conducted among all sampled counsellors. In addition, interviews will also be conducted with key informants in this case, the facility managers and staff at the district health management team. The interviews will be recorded on a digital recorder and some notes will be taken by the research assistant. The interviews will require more probing and although there is an interview guide prepared, the interviews will be as in-depth as possible. Interviews are very useful as they provide an opportunity to capture the complexities of people's perceptions and experiences (Patton, 1987). Key informant interviews with the facility managers and policy makers will give insight into the environment in which the counsellors operate and/or expectations from the policy makers. That information will be useful in framing the environment and demands that counsellors have to deal with as they implement the HCT policy and to an extent validate some claims that Lipsky makes in the assumptions highlighted in the introduction.

## **2.5 Justification for Data Collection Methods**

### **2.5.1 Document reviews**

Document reviews are necessary to ensure that the researcher is familiar with the content of policy and can then give informed feedback about the policy implementation process. Such familiarity is very important as it helps the researcher to give a critical analysis of what is on paper and the actions being taken on the ground. The reviews will also help the researcher to frame the questions to the participants and probe where needed. After reading the documents, the researcher will make comparisons between issues arising from each document and reflect on policy intent and experience of policy implementation. Furthermore, the reviews will provide a background to policy change communication and implementation and shed more light on what was intended in introducing the policy and actual implementation at the community level.

Document reviews will be important in guiding purposive sampling and also familiarize the researcher with content and context of the study (Mack et al., 2005; CDC, 2009).

### **2.5.2 Individual In-depth Interviews**

Qualitative researchers highly recommend the use of individual in-depth interviews to explore social phenomena (Lofland and Lofland, 1995, Patton, 2002). This method emphasizes the use of verbal communication and often effectively brings out a participant's attitudes as well as perceptions or expectations concerning a particular issue (Lofland and Lofland, 1995). The objective in using this method will be to elicit deeply rooted attitudes, perceptions and experiences especially from the HIV counsellors who have first hand experience with implementation of the HCT guidelines. In-depth interviews will be conducted individually with HIV counsellors, facility managers and policy officials. Most of the data coming from the HIV counsellors will be triangulated with data from the facility manager or people in-charge.

### **2.5.3 Observation**

The researcher will take time to observe the environments in which the HIV counsellors work. Some of the areas of observation will include the numbers of people waiting to be attended to by the HIV counsellors, the general ambiance at the facility and the flow of clients to and from the facility. Observations will be done in the 10 facilities where the researcher would have interviewed the managers. In seeking permission from the ministry, the researcher will include permission to observe activities at the facilities. 45 minutes will be spent on observation after interviews with the facility managers (that way the researcher would have created rapport with the managers). The researcher will NOT observe any HIV counselling session for ethical reasons. Merely observing the facility will give the researcher more context of the environment in which HIV counsellors work. The researcher will record his observations into a journal, which will be used for data analysis and interpretation.

#### **2.5.4 Researcher Journal**

Journals are vital in highlighting thoughts, feelings and reflections and help to triangulate data from different sources on behaviour (Hyldegard, 2009). They also tend to improve rigour in qualitative research (Clayton and Thorne, 2000). The researcher will keep a journal throughout the study and will allow him to write down his reflections and experiences from both formal and informal sources of data.

#### **2.6 Data Management**

All interviews and discussions will be recorded apart from the conversations that will be informal. The audio records will be transferred onto the researcher's computer and stored in folder protected by password. The researcher and the assistant (with permission from researcher) will also store the notes from the field including the researcher's journal in a secure place only accessibly.

#### **2.7 Data Analysis and interpretation**

Since the study is qualitative, it will make use of qualitative methods of data analysis. It will basically consist of identifying, coding and categorizing patterns found in the data collected (Bryne, 2001). Using thematic analysis, the researcher shall use the theory of street-level bureaucrats and the assumptions to identify codes and themes. Thematic analysis reveals prominent themes in a text at different levels (Attride-Stirling 2001) and so provide a rich, detailed and holistic account of the data (Braun and Clarke 2006). The codes will be derived from the SLB theory, which will include data related to the motivation/inspiration of the HIV counsellors to enter public service.

In order to identify these themes in the transcribed data, coding will be used. Coding is the identification of passages of text (or other meaningful phenomena, such as parts of images) and applying labels to them that indicate they are examples the assumptions or tenets of Street level bureaucracy. Identification of themes and codes will be done both manually and using an



application called HyperRESEARCH. The Software enables coding and retrieval of source material, theory building, and analyses of data. With its multimedia capabilities, HyperRESEARCH allows one to work with text, graphics, audio, and video sources. It is fully cross-platform enabling the researcher to work with both windows and MacOS and can send files across the platforms.

Manual coding and thematic analysis will accompany the use of the software. Data from same sources like the HIV counsellors will be compared to ensure that the codes are representative and relevant. The same way, responses from policy officials will also be compared to each other to get similar codes. Since at the start of the qualitative data analysis only simple codes will be written with simple descriptive summaries of what the HIV counsellors will say, inevitably even descriptive summary will need some form of interpretation. These interpretations will entail explaining behaviour and phenomena using Lipsky's SLB theory and the assumptions set from the start. Other codes formulated will include actions to represent any form of coping mechanisms.

## **2.8 Ethical Consideration**

Objectivity and neutrality will be maintained during the research by avoiding any bias towards a particular inclination or persons. Ethical clearance from the ethics committee at university of Cape Town Human Sciences Research Council as well as from the ethics committee that approves all research studies in Zambia will be obtained, a condition laid down by the Ministry of Health. In addition, permission and consent from the Government of Zambia through the Ministry of Health's Permanent Secretary will be obtained so as to conduct the research in that institution and interview staff. Written consent will be obtained from all the informants and the participants will be ensured that the study is purely on voluntary basis and that they are free to withdraw at any time without penalty. Anonymity, giving pseudo names to the participants and keeping transcripts in secure folders locked by passwords only accessible to the researcher will guarantee confidentiality.

## **2.9 Limitations**

The limitations foreseen in the study include time and financial resources. Lack of time might not allow the participants to share all that they would want to share and thus may affect the amount of rigour in the data collected. Financial resources are also scarce as the researcher will be funding the study by himself and thus some logistics like travels may prove to be difficult and delay the data collection. Moreover, the interviews will need adequate time from the HIV counsellors but they are usually found in busy working environments that may restrict them to spend much time on the study. Another limitation lies in the fact that the researchers will not interview HIV counselling clients due to ethical reasons. This means that a good amount of information will not be collected to triangulate findings from HIV counsellors, facility manager and policy makers.

### **2.9.1 Risks and Benefits**

The benefits of the study are not at an individual level. It is anticipated that the results will inform policy change and implementation of the guidelines, thereby making counselling and testing for HIV both ethical as well as relevant to the Zambian population. The study is not likely to pose any risks to the welfare of the participants, however, should there be any psychological distress resulting from sharing of personal or professional experiences with counselling HIV positive persons, in particular from counsellors, a referral system for counselling will be employed. This will involve referring the participants that may need counselling to accredited counsellors with the researcher paying for transportation costs for the participant. Consultation fees and any other costs one may incur will be the responsibility of the participant.

## **3.0 Reflexivity and Rigour**

The researcher was born in Zambia, in Lusaka District (the study area). He spent eight years working in HIV and AIDS response particularly targeting low-income areas. The researcher is also a member of the Zambia Counselling Council, a professional body for all practicing Counsellors in the country. This gives him access to wide range of Counsellors in the public

health facilities and understands how to approach them. He is culturally aware of the social norms among the study participants, thus the interviews will be sensitive of the culture of the participants. His experience with health policies in the country, particularly the HCT policy, will be useful in developing themes of the experiences and also seeking clarity from the participants. The researcher is also fluent in Nyanja, the local language often used by the population, but the study will be conducted solely in English. This will save on time to transcribe and translate the interviews. Moreover, all participants speak English, which is the only official language in Zambia.

To ensure rigour in the research process, the following precautions will be taken into account with regards to validity and reliability in qualitative studies:

- i. Constant reviews of question guides in line with research objectives.
- ii. Comprehensive recording of data using audio-recorders and detailed transcription involving two individuals. The transcriptions will be compared for consistency and any discrepancies will be resolved by listening to the recordings together.
- iii. Triangulation shall involve three approaches: across data sources (Counsellors, facility managers, policy officials and informal informants; across data collection methods (in-depth interviews, informal interviews, journal reflections and document reviews).

#### **4.0 Timeline**

Data collection will take 4 weeks from the time of ethical approval. Data analysis, interpretation and report writing will take 8-10 weeks.

#### **4.1 Structure of Dissertation**

This minor dissertation will consist of four parts:

Part A- Protocol

Part B-Structured literature review

Part C- Journal ready article

Part D- Appendices

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## **PART B: Structured Literature Review**

## **1.0 INTRODUCTION**

Policy implementation often occurs in a complex manner with a myriad of factors affecting the way that it is implemented; for example, financial and human resources needed for the policy to be implemented, systems to monitor the implementation and knowledge about the policy can all influence the outcome of a particular policy. Perhaps the most complex of these factors are human resources and the way that policy implementers affect and are affected by the process of implementation. Various studies have investigated the behaviours of implementers, such as frontline workers in health service provision. To understand the factors and environments in which such practitioners operate generates understanding of how policy implementation may occur on the ground and accounts for certain unexpected and/or unwanted results.

Michael Lipsky in his classic study of frontline workers, which he termed as ‘street-level bureaucrats’, provided insights into the behaviours of frontline workers in public service (Lipsky, 1980). His work has significant impact on modern day literature on policy development and implementation. He raised attention to discretions and freedoms of street-level bureaucrats in policy implementation. To date, his theory has influenced debates on whether discretion is still operational in public policy fields or has been curtailed. Scholars who have considered debates on the curtailment and continuation of discretion in public service have identified significant differences between the two arguments. The differences focus on the desire of managers to secure control and the workers’ desires to resist control and opt for discretion (Evans and Haris, 2004).

This is a literature review of various global experiences in implementing public policy and understanding the behaviours of frontline workers through the lens of street-level bureaucracy. It also attempts to highlight lessons learned in implementing public policy within the context of health systems and documents the impact of policy implementers on policies. The review also



highlights what influences policy implementers to implement or not implement policies accordingly.

## **2.0 LITERATURE REVIEW OBJECTIVES**

**Guiding Question:** How do health policy implementers influence policy implementation and what influences their practices of implementation?

To inform this research, the objectives of this review were:

1. To understand Street Level Bureaucracy and how it has been applied in health policy research.
2. To understand the influence of frontline health workers on policy implementation across polices and countries
3. To explore the general experience of policy implementation in Zambia
4. To highlight gaps in the literature regarding HCT policies and practices among Counsellors to justify the study objectives.

### ***2.1 Literature Search Strategy***

This review was done based on a search of published literature relevant to the study topic. Due to the fact that there was not adequate literature on HIV counselling and testing practices and experience in Zambia alone, the literature search was broadened to cover policy implementation and factors that affect implementers. In addition, the search was broadened to exploring experiences of policy implementation in general. In searching for the literature, various search engines as well as online research journals were used such as Google Scholar, PubMed search, National HIV/AIDS data in Zambia and the ministry of health website.

### *2.1.2 Key Words*

The following key phrases were used to search for relevant literature based on the literature review objectives around policy implementation and impact of implementers:

- Policy implementation
- HIV counselling and testing
- Experiences of health workers
- Public policy
- Implementation experiences

## **3.0 SUMMARY OF LITERATURE**

### *3.1 Street-level bureaucracy*

Michael Lipsky (1980) coined the concept of ‘street-level bureaucracy’ as a core theme for what would become a popular theory in public policy. His concept led to a wide discourse around the nature of the freedoms of frontline workers and their relative autonomy from organisational management and superiors (Evans & Haris, 2004). He termed this autonomy as professional discretion, and argued that it is what frontline workers exercise to determine how they would implement a particular policy including how citizens can access such a policy. Since then, his claims on professional arguments and freedoms have attracted scholarly attention including development of insights that are useful at micro levels and in different contexts.

Lipsky coined ‘street-level bureaucracies’ as a term to describe government institutions that are responsible for delivering services to citizens. These institutions include ‘welfare departments and police, the schools, legal services offices, lower-level courts, clinics and other institutions with agents who interact with citizens and are responsible for dispensing benefits or allocating public sanctions (Lipsky, 1980). Lipsky gave examples of street level bureaucrats such as

teachers, police officers, nurses and judges. He claimed that that the best way to understand public policy is not in the way it is portrayed as developed in “legislatures or top-floor suites of high-ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street-level workers’ (Lipsky 1980, p. xii). His argument was that instead of formal legislature and policy statutes, frontline workers’ decisions, routines they develop, initiatives they come up with to cope with challenges and expectations, effectively become the public policies in reality (ibid).

Furthermore, Lipsky argued that the way that the public experiences policy is also dependent on how front-line workers understand and interpret policy. For example, a policy that is aimed at providing free health care to the poor, will very much be implemented according to how front-line workers allow or inhibit people to utilize the services understand the policy. Lipsky argues that policy implementation in the end comes down to the people who actually implement it, the street level bureaucrats (Hudson and Lowe, 2004). He purported that the roles of the frontline workers in policy making are characterized by two features of their work: (1) comparatively high degrees of discretion; and (2) relative freedom from organisational management and authority.

Lipsky’s (1980) classic study of ‘street-level’ bureaucracy has provided a perspective analysis of front-line workers practices particularly in public organisations. His model has gained acclaim and is increasingly being used in understanding policy implementation and objectives. This has implications on policy formulation as well as policy change. Once policy makers identify the gap between policy objectives and resources that are at the disposal of front-line workers, front-line workers may be less compelled to develop coping mechanisms, which may also be detrimental to the policy objectives. There may also be a need for implementers to be part of the policy development process, so that policy makers can account for any possible variation from policy from the outset by prospectively looking at how the front-line workers may be able to adapt the policy implementation to their work contexts.

A study of social workers (Ellis, 2013) provided a critical examination of the theory's element of discretion within public agencies. The study concurred with the main critique that Lipsky gave on management control of discretion but argued that Lipsky did not give sufficient attention to the role of professionalism and the possible impact of professionalism on the relationship between frontline workers and their managers and the nature of discretion. The study used a case study approach to study social workers within a local department of social services (ibid). The implications of the findings are that frontline workers' professional status and the perks that come with it, has an impact on the degree of their discretion.

### ***3.2 HCT implementation and influence of health workers across countries***

Understanding the role of implementers in policy formulation and implementation is important for any health policy development and change. Some literature was found when searching for HCT, which was more on testing for HIV rather than on counselling itself. Further, literature on HIV counselling often referred to either access or benefits of counselling rather than looking at Counsellors as service providers (Obermeyer and Osborn, 2007; Marum et.al, 2006; Chan & Chung).

It is well acknowledged that in order to initiate timely HIV treatment and ensure widespread prevention of further infections, one must first know their HIV status. HCT is therefore paramount as it is through HCT that uninfected individuals can take measures to avoid becoming infected and infected individuals can avoid transmission to their sexual partners or children. It is also important for preventing mother-to-child transmission and increasing access to HIV/AIDS care, including antiretroviral therapy (ART). Furthermore, HCT is the first step in referral to care and support services.

Public health workers are trained in providing HCT, both VCT and provider initiated HIV counselling and testing. As opposed to VCT where individuals seek HCT on their own initiative, provider initiated HCT refers to HCT that is routinely recommended by health care providers to persons attending health care facilities as a standard component of medical care. With this

approach, an HIV test is recommended for all patients whose clinical presentation might result from underlying HIV infection or as a standard part of medical care for all patients attending health facilities in areas of high HIV prevalence. In 2007, the World Health Organization (WHO) issued guidelines recommending that countries and organizations adopt provider initiated HCT to increase HIV testing rates (WHO, 2007).

Generally, HCT is well implemented in many countries, more so in countries hardest hit by the pandemic such as those in sub-Saharan Africa. In Uganda, routine HCT identified a large number of undiagnosed HIV infections and HIV-discordant partnerships among patients and their families (Wanyenze et al, 2008). However, inadequate human resources present a challenge in most health care centres hence health workers were reported to be under pressure to deliver with limited time, space and personnel (ibid). The use of community health workers was suggested as a way to cushion the problem in the case of Uganda. And in recent times it is not only Uganda that has incorporated community health workers in HIV service provision, but other countries in the region as well.

Community health workers and lay Counsellors have also been known to have an influential role in the delivery of HCT services. Compared to other health workers, community health workers are well positioned to understand and influence patients' behavior, including acceptance of HCT. Experience in Haiti shows that this was the case and they were able to enhance community uptake of services and target vulnerable groups (Heunis et al, 2011). In South Africa too, community health workers were found to play a very important role in HCT and worked together with professional health workers to engage patients about their fears on HCT (ibid). In many sub-Saharan countries, Community health workers are being trained to visit the homes of antiretroviral treatment patients. They offer home-based HIV counselling and testing services to household members (USAID, 2011).

However, HIV also affects health workers who are important in implementing HCT and if not addressed comprehensively has the potential to affect their delivery of health care to clients, thus hindering the successful implementation of HCT. A study to explore the impact of HIV/AIDS on health workers in Zambia described their challenges and recommended supportive measures. The study revealed that HIV/AIDS had a negative impact on workload and had considerably changed or added tasks to already overburdened health workers, most of whom expressed fear of infection at the workplace and suffered emotional exhaustion which sometimes affected their output (Dieleman et al, 2007). This was particularly the case for nurses and clinical officers. However, it is not clear from the study what mechanisms nurses and clinical officers developed to cope with those challenges.

Despite the good implementation of HCT, the review did not find evidence that suggests what role health workers played in coming up with any guidelines or policies that govern HCT service provision. Although there seems to be universal agreement on the importance of progressive policies as a pre-requisite for better health outcomes, scholars and policy makers tend to understand the process of policy making from different perspectives. The need to involve policy implementers in policy development is somewhat not as clear in literature as the need to involve service beneficiaries.

### ***3.3 Influence of health workers over policy implementation across policies and countries***

Politicians, managers, and the dispositions of street-level bureaucrats have also been known to have an influence in shaping actions at the frontlines of policy implementation. It is thus important to note that individual incentives and beliefs are central to local responses and that policy in principle cannot always direct what matters to outcomes at the local level. Therefore, effective implementation requires a strategic balance of both pressure from the top and support from the bottom (McLaughlin, 1987).

Implementers have a huge role to play in setting the policy agenda and formulating the policy so that when it comes to implementation, they would not be forced to implement impractical policies. Furthermore, there are a number of policies that demonstrate inter-relationship of policy makers and implementers, which affects the felt reality of policy at the grassroots level (Wells, 1996). Carefully managing the balance between policy-makers ambitions and the reality of the implementers is essential in the success of any given policy (Lipsky, 1980).

May and Winter (2009) looked at the implementation of the employment policy reforms in Denmark where their research showed a large percentage of caseworkers emphasizing actions that were consistent with the national employment reform goal of getting clients into jobs quickly. However, the influence of politicians and managers in bringing this about was found to be relatively limited as compared to the influences of caseworkers' understanding of policy goals, their professional knowledge, and their policy predispositions.

Understanding the role of implementers in policy formulation and implementation is important for any health policy development and change. Studies were found during the review that showed involvement of implementers in policy development (Branson, et.al, 2006; Obermeyer and Osborn, 2007; Marum et.al, 2006; Chan & Chung).

### ***3.4 Factors influencing health workers policy implementation***

#### ***3.4.1 Participation in Policy Formulation***

It has been argued that if nurses, or indeed any frontline workers felt frustrated and excluded from critical decisions including policies, it is likely that they would not be proactive in implementing the policy or making it work. This can be exasperated by the fact that these public servants work in often harsh conditions marred by low remuneration, heavy workloads, fewer staff and inadequate infrastructure and facilities (WHO, 2007). The outcome of such circumstances may be a health worker who is not only frustrated but may reflect such frustrations on the clients that he/she has to serve on a daily basis.

Similarly, when health workers feel that they have been involved in the development process of a particular policy, they are more likely to have positive attitudes towards such policies and consequently commit to proper implementation (J' Occup Health, 2007). The feeling of being part of the process of developing policy also enhances ones feeling of control of what the policy will achieve. In fact, the lower the engagement of implementers in policy development, the higher the chances of unanticipated and unwanted impacts (Gilson et al, 2003). Therefore, policy makers must think of the nature of the policy they are about to develop, how it influences the implementers and how the implementers might respond to it. And the best way to do this is by engaging with implementers right from the beginning of policy development (Gilson and Erasmus, 2009).

### *3.4.2 Values, beliefs and attitudes*

Of course not every health worker ends up not implementing policies accordingly. However, those who change policies to suit them and their environment, or completely ignore policy requirements do so due to different factors ranging from personal to structural, some within their control and others without. At the personal level, failure to implement may be as a result of personal beliefs and values (Simpson, et.al. 1996; J' Occup Health, 2007). These values then affect one's attitude and behaviour. Views, values and beliefs of frontline workers often inform implementation of health policies; as to whether it will be done accordingly to set guidelines or not. For example, provision of health services to sex workers has for a long time been a problem for most health workers (Phillips & Benoit, 2013). Because traditional communities seemingly disapprove sex work, health workers tend to associate sex workers with stigma by associating them with the disapproved behaviour.

The impact of personal values and beliefs can be too strong on frontline workers to such an extent that they would rather ignore what the policy says than go against their own values. For example a study on nurses' adherence to Universal Precautions for venipuncture found that even



when the nurses had more to gain from the policy, they were not adhering due to social norms and personal beliefs (Godin, et al., 2000). A promising policy therefore must be coupled with efforts to address personal values and beliefs of the implementers and provide a safe environment for them to air their views and fears.

### *3.4.3 Knowledge of Policy*

Another factor that may affect health workers attitudes and approach to policy is their level of knowledge. Lack of adequate knowledge about policy, its existence or content affects the way that health workers will approach implementation (Becker, et al 1990). However some experience has shown that despite having adequate knowledge there are still many challenges that health workers might face that would hinder them from implementing whether deliberately or not (Ocran and Tagoe, 2014). This goes to say that even when health workers know the tenets of a particular policy, it is possible for them to be affected by their values or challenges that they face in the course of their jobs.

In some cases policy implementers are not in the know regarding new policies since technocrats design them. Furthermore, politics play a huge role on policy formulation; and implementers tend to have no power to engage with political leaders who determine and set the agenda (Crosby, 1996).

### *3.4.4 Challenges of implementers*

Literature on challenges of health workers is overwhelming, with evidence of challenges that speak to human resources (Uneke et al, 2007; Sikwese et al, 2010), health financing (DoH, 2011, Kumar et al 2011) poor infrastructure, unmanageable demand and clientele and lack of motivation among health workers (Francoa et al, 2002). In Uganda for instance, health workers faced challenges in implementing the PMTCT programme. Health workers were knowledgeable about the benefits of the programme and had already bought-into the concept of the programme.

Unfortunately the challenge they faced was from the beneficiaries who in most cases were unwilling to test. Low community awareness on PMTCT was also a challenge that somewhat was not the responsibility of health workers responsible for provision of PMTCT (Nuwagaba-Biribonwoha, et al, 2007). Crosby (1996) also investigated organisational challenges of policy implementation. The study revealed that policy implementation was not a smooth process, but that it is often interrupted by such challenges as unavailability of resources, equipment or space for health workers to perform their tasks.

Inadequate resources also significantly impact frontline workers and their ability to implement policy. Lack of resources tend to remove the motivation of public health workers from doing their job especially when they know that there is not enough resources to capacitate their job execution in an effective and efficient manner (Atun and Olynik, 2007). Lack of incentives other than money also tends to be a challenge for the health system and health workers lose the morale (ibid).

### ***3.5 Experience of health policy implementation in Zambia generally***

The process of public policy making in Zambia occurs in a broad policy environment comprising both official and non-official players. Official players occupy formal state positions established by the political community and acquire guidance on the exercise of that authority from the country's constitution. These include members of the executive, the Judiciary and the legislature (Burnell, 2003). Non-official players on the other hand derive their membership in organized civil society and interest groups. While policy formulation seems to follow a top down approach, policy implementation is generally a bottom up kind of approach, with frontline workers usually responsible for implementation of policies (Kingdon, 2003).

Gilson et al (2003) highlight the important role played by key political figures in Zambia such as the Minister of Health in the process of health policy development during moments of major political change in the country by choosing which proposals to take for implementation. A

briefing paper by Buse et al (2008) also suggests that the study of health policy needs to take into account factors such as the role of the state, the interests of various actors and the manner in which they wield power, the nature of political systems and their ways for participation. Furthermore, the guiding principles of informal and formal policy processes must be considered as they play an important role in both formulation and implementation of policies.

Health policy making and implementation in the Zambian health sector is also a function of many actors, both local and international. The goal of the health sector is “to improve the health status of people in Zambia in order to contribute to socio-economic development.” (MoFNP, 2011:17). The overall vision is to ensure “equitable access to quality health care by all by 2030”(ibid: 17). The National Health Policies and Strategies of 1992 provide the overall policy framework within which health services are provided (Mwanza, 2010). Others include the Public Service Reform Programme (PSRP), the National Decentralisation Policy and other national policies, including National Health Strategic Plans in which the health sector is operating.

Since 1992, the Zambian health sector has been pursuing health care reforms aimed at providing citizens with equity of access to cost-effective, quality health care as close to the family as possible (MoH, 2005). The reforms were subsumed in the general economic restructuring which began in many countries, especially the developing countries with an emphasis on the market, including privatisation of care provision and on partially off-loading the responsibility for financing services from government to service users through direct payment or community financing schemes (Blas and Limbambala, 2001). The controversial introduction of user fees at all public health facilities in a bid to increase resources to the health sector and the decentralization of the health care delivery to health boards has been a key feature of the reforms.

The idea of charging communities for health services was based on the assumption that people already paid high fees for private health care provided it was of good quality. Therefore, it was

concluded that if people were willing to pay for private services, they would equally be willing to pay for government services, as long as quality was guaranteed (Van Der Geest et al, 2000). However, implementation of the user fees has never fully succeeded since introduction. Evidence from other countries suggests that health workers play a key role in determining the success of a fee removal policy, but also find the implementation of such a policy challenging (Carasso et al, 2012; Gilson and Walker, 2004). In 2006, government abolished user fees at primary health care facilities in rural and peri-urban areas an effort to ensure universal access to health care, especially for the poor who in most cases were unable to pay (Masiye et al, 2008). Furthermore, because the policy was introduced against a backdrop of a major shortage in qualified health staff, it was unsustainable. In 2011 when a new government took office led by Michael Sata, it was announced that user fees had further been abolished in all health centres both rural and urban.

It has been reported that this has greatly affected health care delivery as health workers are struggling to cope with the long queues at health facilities, amid shortages of staff. Carasso et al (2012) report that while health workers expressed satisfaction with the removal of an impeding factor for many disadvantaged patients leading to an increase in the number of patients visiting the facilities, they also complained about an increased workload and worsening working conditions which they felt was due to the fact that there were no additional resources to deal with the increased demand or replace the loss of revenue generated by fees.

In addition, the health reforms themselves have not had the intended impact of improving the overall performance of the health sector. Martineau and Buchan (2000) point out that whilst the reforms focus on changes in financing and organisational structure, they often neglect the staff, thereby resulting in inappropriately skilled staff for new tasks. Furthermore, the Ministry of Health (2005) reports that planned interventions were not being implemented simply because there were either not enough staff at all or not enough suitably trained in the health facilities to provide the services.

Exploring the implementation of health financing reforms in Zambia and South Africa in the early 1990's, Gilson et al (2003) found that frontline workers had vital influence on policy implementation and impact, arguing that the lower the engagement of implementers, the higher the chances of unanticipated and unwanted impacts. It is thus clear that having the right number of qualified staff is necessary for successful implementation of any programme.

The country receives significant amounts of funding from Global Health Initiatives for implementation of many health programmes, particularly HIV/AIDS programmes. However, human resource shortages within the health sector tend to hamper implementation of many of these (Hanefeld and Musheke, 2009). There are not enough health workers to effectively implement health policies and to deliver universal access to health care, especially HIV prevention, treatment and support. As access to ART in the country continued to grow, the non-availability of trained health personnel became an important limiting factor in the provision of services (Kruse et. al, 2009).

Because of this, government in 2005 agreed on task shifting, a project advocated for by the World Health Organisation (WHO) in order to attain the MDGs on health and to expand the pool of human resources for health. This meant that a delegation of tasks whereby tasks were moved from highly specialised health workers to less specialised ones who could be trained to do the task (WHO, 2007). In this case, tasks normally performed by doctors, nurses and pharmacists, such as, HIV counselling were re-allocated to other health workers, which also saw the introduction of HIV counselling as a profession. Community volunteers began to be trained as lay Counsellors in order to cushion the problem of staff shortages generally and with specific reference to HIV counselling and testing. Before the introduction of lay HIV counsellors, HIV counselling and testing services were provided primarily by nurses during their free time and the challenges faced in human resources did not make this any easier as some health centres did not have staff dedicated to providing these services (Sanjana et al, 2009).

### *3.6 Relevant theoretical framework*

A number of frameworks or models exist to provide alternative understandings on processes of policy-making and how they play out in implementation. There are mainly two broad approaches that help understand policy making and implementation better namely top-down and bottom-up approaches (Buse et al, 2005).

#### *3.6.1 Top-Down*

The first is the top-down approach, which sees policy-making and implementation as two distinctive activities. In this approach, policies are set at a much political level and are then passed to subordinate levels responsible ensuring that it is implemented. The top-down approaches views policymaking and implementation process as smooth and logical (Darling-Hammond, 1990) and that policymaking occurs in a logical, linear and comprehensive manner (Sabatier & Mazmanien, 1979). Experts and senior public servants are viewed as people who provide neutral information and/or inputs.

Of course in reality policy making and implementation process, it is often affected by many internal and external factors. Others have argued that the ideal world does not allow for policy to occur in a rational and linear manner. In fact, the policy-making process is often affected by a myriad of challenges including the political environment and personal interests (Kingdon, 2003; Lindblom and Woodhouse, 1993; Sabatier, 1999; Sato, 1999). The top-down approach is further criticized for not taking into account the role of actors who are not mainstream policy makers, especially implementers (Sato, 1999; Peters, 2002; Hudson and Lowe, 2004). The top-down approach does not seem to present a realistic scenario of how policy is formulated and the environments in which it gets to be implemented.

#### *3.6.2 Bottom-up*

The second approach is the bottom-up model. Contrary to the top-down, this approach recognizes the crucial and active role that subordinates such as implementers play in implementation and that they often have some discretion to tweak objectives of policies and alter the way it is implemented (Lipsky, 1980). Proponents of the approach claim that the top-down approach ignores the influence of implementers who have strong power to influence policy in their own right (Howlett and Ramesh, 2003).

In addition it is argued that bottom up-policy making is necessary for effective implementation. For example, Thomas and Grindle (1990) argue that the top-down model is not effective hence they proposed an interactive model that allows for space for consultation and antagonism necessary to secure effective implementation. Furthermore, Gunn (1978) considered the bottom-up approach as necessary for effective implementation. Indeed this approach also accounts for the formal and informal relationships between implementers and policy makers over time (Barret and Fudge, 1981; Howlett and Ramesh, 2003).

In a democratic society with diverse sources of knowledge and expertise, it is only plausible that policy development be built on mutual respect and interaction between policy makers, implementers and the people for who policy is intended to benefit. Of the two approaches presented, the bottom-up approach seems more friendly and suitable to creating such an enabling environment for shared policy responsibility. It comes with its own challenges, like the difficulty of measuring impact of this interaction between implementers and policy makers (Hogwood and Gunn, 1993). Nonetheless, it is an approach that has led to various other lines of thought in policy making.

One proponent of bottom-up approaches is Lipsky (1980), who specifically identifies implementers as critical influencers of policy, and regards frontline workers as influential in policy and purports that they are the ones who often shape policy. He defines street level bureaucrats as frontline workers who are responsible for implementing policy and whose job is involves interacting with citizens (Lipsky 2010). Examples of street-level bureaucrats include

health workers, police officers, teachers and judges as such bureaucrats. Lipsky argues that policy is ultimately what the street-level bureaucrats understand and interpret it to be (Hudson and Lowe, 2004). However, some of the disadvantages of bottom up approaches are that evaluating the effects of a policy becomes difficult, as well as difficulty in separating the influence of individuals and different levels of government on policy decisions and consequences (Buse et al, 2008).

#### **4.0 Gaps in existing literature**

Some gaps exist in the current literature concerning policy implementers, their impact on policy and the factors that impact them. In Zambia such literature was scarce compared to regional and global data. Literature found did not show that there is an interest in understanding the significance of policy implementers not only in implementation, but also in designing on policy during the initial stages. The researcher was unable to find previous studies that have looked at HIV counselling in particular and how health workers impact policies around HIV. The paper that was similar to the study of HCT policy implementation was one on implementing routine provider initiated HIV testing in public healthcare facilities in Kenya by Evans and Ndirangu (2010).



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## **Part C: Journal “ready” manuscript**

# Exploring experiences of HIV Counsellors towards the HIV Counselling and Testing Policy in Zambia's Public Urban Health Centers<sup>1</sup>

## ABSTRACT

**PURPOSE:** This research studied HIV counsellors in Zambia's public urban health centers as a case study in order to understand the role of frontline workers in policy implementation. Lipsky's theory, which frames frontline workers as 'street-level bureaucrats,' was used to understand the behaviour of HIV counsellors. The study assessed the work environments of the HIV counsellors and how they implemented the HIV Counselling and Testing (HCT) guidelines on a daily basis. It explored the theory's distinct claims on discretion and coping mechanisms and how they applied to the specific context of the HIV counsellors as implementers of the HCT policy. The assumption was that in order for frontline workers to cope with the demands of their work and clients in public health facilities, they develop certain coping mechanisms using their discretion. Such coping mechanisms range from changing the policy guidelines to suit the needs around them, to deliberately ignoring some of the guidelines. The study investigated the various coping mechanisms HIV counsellors developed in order to implement the stipulated HCT guidelines.

**METHODS:** Purposive sampling yielded 31 in-depth interviews with HIV counsellors (15), facility managers (10) across 15 health centers in Lusaka district. The 15 health centers were sampled from the list of all (28) government owned clinics in Lusaka; data collection ended after reaching saturation. Also interviewed were policy makers conveniently selected from the Ministry of Health (2), Ministry of Community Development, Mother and Child Health (2), National AIDS Council (1) and the Zambia Counselling Council (1) between November and December 2013 in Lusaka district. Interviews were audio-recorded and later transcribed. No data was collected from HIV testing clients due to ethical limitations. The qualitative data was then coded using thematic analysis and themes were identified using HyperRESEARCH software.

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<sup>1</sup> Manuscript prepared as an original article for the SAGE Journal of Health Services Research and Policy.

**RESULTS** The study found that the HIV counselors, like most frontline workers faced many challenges such as poor infrastructure, heavy workloads, having a large numbers of clients, negative attitudes from nurses and low wages. However, they also had a great amount of freedom from organisational management, as they were the primary custodians of the HCT policy. Further, inadequate resources did not seem to hinder them from delivering quality service to the best of their ability given the circumstances. Some of the coping mechanisms they developed included rationing of their time by spending less time on clients, sending some clients away and using rooms that were not HIV counselling friendly.

**DISCUSSION** These results reflected some common work environments for most frontline workers in Zambia. They validated Lipsky's claims concerning the role of frontline in policy implementation as evident in the degree of discretion that HIV counsellors exercised. HIV policy was indeed implemented according to how the HIV counsellors understood it. Given that there was not enough supervision from managers, who were not conversant with the HCT policy, the HIV counsellors exercised a great deal of discretion in their daily routines. The findings also showed that implementers had significant 'power' to change policy as it was intended. They differed with some of Lipsky claims, as the behaviours of the HIV counsellors in most cases did not represent what Lipsky claimed to be common among street-level bureaucrats.

### **Implications and Contribution**

The study attests to the need for greater and meaningful involvement of health workers in policy formulation. Since there was no literature that had looked at what coping mechanisms health workers develop amid challenges in the health system in Zambia, the study provided a starting point into investigating how counselors' coping mechanisms affect implementation and what factors influence health workers' attitudes and experiences with health policy implementation.

### **Key Words**

Discretion, coping mechanisms, implementation, HIV counselling, bottom-up policy, Lipsky



## INTRODUCTION

### *The HIV Response in Zambia*

In Zambia, during the period of the National Health Strategic Plan [1] the Government took major steps towards strengthening the policy framework for fighting the HIV&AIDS epidemic. This included the Ministry of Health developing action plans on the implementation of HIV&AIDS at the work place, adopting a National Action Plan for the implementation of AIDS-related activities which was developed in 2002, and finalizing and adopting the HIV&AIDS Strategy by Cabinet [2]. Furthermore, in 2003, the Central Board of Health established the National HIV&AIDS and Infection Prevention Committee.

In 2004, the counselling testing and care programme was strengthened and expanded to 420 centers countrywide. Similarly, the Prevention of Mother to Child Transmission (PMTCT) programme was strengthened and expanded to 220 centers [2] counselling testing and care has been identified as the entry point for PMTCT.

Anti-Retroviral Therapy (ART) activities were also scaled up. In view of this, a total of 700 medical personnel were trained in the administration of ART and management of opportunistic infections. The number of centers providing ART increased from 2 in 2003 to 84 in 2005. As a result of all these efforts, the level of ART awareness improved significantly leading to an increase in the number of eligible patients accessing ART from 4,000 patients in 2003 to about 32,144 by August 2005 [3, 2].

### *HIV Counselling and Testing in Zambia*

Until recently, the primary model for providing HIV testing and counselling has been client-initiated HIV counselling and testing, also known as voluntary counselling and testing (VCT) - whereby individuals actively seek an HIV test at a health or community-based facility. However, there was also provider-initiated HIV counselling and testing which involved the health care provider specifically recommending an HIV test to patients attending health facilities. In these

circumstances, once specific pre-test information had been provided, the HIV test would ordinarily be performed unless the patient declined.

The World Health Organisation (WHO) and the joint United Nations Programme on HIV&AIDS (UNAIDS) have re-emphasized the condition of the 3 C's as the underpinning principles for the conduct of HIV testing of individuals. These are Confidential, Counselling and Consent [4]. In 2007, UNAIDS/WHO issued guidance on provider-initiated HIV counselling and testing in health facilities to support increased uptake and improve access to HIV prevention, treatment and care [4].

Many countries in the world and in sub-Sahara Africa have developed guidelines for HIV counselling and testing, including SAfrica, Uganda, and Ethiopia. Furthermore, provider-initiated HIV counselling and testing has already been implemented in a range of clinical settings in several low and middle-income countries, including Botswana, Kenya, Malawi, Uganda and Zambia, as well as in pre-natal settings in parts of Canada, Thailand, the United Kingdom, and the United States [5].

#### *The HCT Guidelines in Zambia*

As of 2006, Zambia had no comprehensive and standardised HIV counselling and testing (HCT) operations. This was despite the fact that more than 16% of the population was living with HIV at that time and the government had declared AIDS a national crisis four years earlier [6]. Indeed by then, the AIDS response was being managed within the legal framework of an act of parliament of 2002 [2] The Act generated national awareness of the epidemic and created an increase in demand for both HIV counselling and testing services. In the same vein, there was an increase in facilities that provided these services. For example in 1999, Zambia had only 21 HTC sites and by 2006 there were more than 450 sites across the country [2].

According to the government, in 2006 a multidisciplinary team representing physicians, Non-Governmental Organisations, public health workers, social workers, laboratory experts and

counsellors was mobilised to develop guidelines for HIV counselling and testing. The team engaged in a consultative process with expert groups including people living with HIV (PLHIV), people with disabilities, the private sector and other key players in the AIDS response [2]. These guidelines were then expected to act as a blueprint for the scaling up of HCT and to assist health service providers to maintain a high quality standard of HCT in Zambia. The guidelines were to be followed by service providers in both public and private health facilities. HCT counsellors in Zambia are often responsible for both counselling and testing for HIV using rapid antibody tests that require finger prick blood samples.

The HIV counselling and testing (HCT) guidelines contain five main sections. Section One provides operational guidelines for HCT. In this section the policy listed the general guidelines for providing HCT and presented models of service delivery. It also set minimum requirements for staff, space, equipment and supplies for HCT including technical requirements for human resources.

Section Two provided specific guidelines for HIV counselling. These were guidelines that assisted counsellors who dealt with clients on a daily basis to provide high quality counselling. They also included specific guidelines before and after HIV testing known as pre and post test counselling respectively. It also included guidelines on referrals and special circumstances for HIV counselling. The guidelines stipulated the detailed steps that needed to be taken by the HIV counsellors in order for the service to be of good quality. It gave a checklist of 23 and 16 items on pre and post-test counselling respectively. The other sections were Section Three on HIV testing, Section Four on Quality Assurance for both HIV counselling and testing; and Section Five on record keeping, data management, monitoring and evaluation.

The aims of the HIV counselling and testing guidelines included standardizing capacity requirements for implementation of HIV counselling and testing services, provision of guidance on programme operations, regulation of HIV testing approaches and technologies for HIV sero-

diagnosis, and to strengthen and support the expansion and extension of HIV counselling and testing services in the public and private sectors, among many others [7].

Apart from the 3 C's that must be applied during HIV counselling and testing, the guidelines also stated that disclosure of results should be done only with the client, record keeping should be confidential and results should not be written unless absolutely necessary. It also gives guidance on partner notification, confidential referrals, family planning services, adherence to human rights, community participation and outreach, and the minimum age of 16 years to be able to give informed consent for an HIV test in all circumstances.

### ***Theoretical background and relevance to HIV Counsellors***

The role of frontline workers in health policy implementation is of much concern in health policy research and evaluation [8,9]. A number of scholars have studied the relationship between policy formulation by policy makers and implementation of such policies by agents [10-13]. Increasingly, even scholars of rational choice models have contributed to understanding this relationship. The rational choice model, like most top-down models, understands policy making as occurring in a rational, linear and comprehensive manner. Experts and top civil servants are seen as providing neutral information (inputs).

Some of the strongest opposition for this top-down model comes from bottom up theorists who argue that policy process does not proceed in such a linear and staged fashion, whereby all the steps are strictly followed. Scholars who criticize top-down models include bottom-up proponents and those leaning on advocacy coalition [30-33].

Lipsky [16], who also identified with bottom-up theorists, his book 'Street-level bureaucracy: Dilemmas of the individual in public services', viewed implementers of public policy as street level bureaucrats, which refers to frontline workers who interact with citizens in the execution of their jobs. Examples of such are health workers, teachers, judges and police officers. However,

these street level bureaucrats face numerous challenges when implementing public policies. They have to respond to the pressing needs of clients despite having very limited resources including funding, time and information to enable them make decisions.

Many frontline workers regard the work they do as technical and distant from politics that govern policy making. However, policies are only implemented when the frontline workers apply them in practice. The majority of citizens do not engage with policies and laws by being aware of them, they rather perceive the way frontline workers make decisions as they deliver their services to be the law. Unfortunately, that is usually not the original version of public policy. Therefore, frontline workers become the initial and arguably most important policy-makers [16].

According to Lipsky [16], frontline workers face a dilemma between the many demands for the services they offer, and the limited resources at their disposal. To deal with this dilemma, frontline workers tend to develop coping mechanisms. These coping mechanisms often affect implementation process and may hinder them from meeting policy goals. Lipsky purports that all frontline workers regardless of the field they are in, be it doctors, teachers, nurses or police officers, etc., tend employ similar kinds of coping mechanisms [16]. He attributes the similarities in behaviours of frontline workers to similarities in their conditions of work and settings.

Furthermore, bottom up scholars have paid particular attention to the contractual structures and incentives that align the interests and motivations of implementing agents with principles of policy-making and expectations of policy makers [14]. It is important to understand this alignment as it helps to bridge the gap between policy development and implementation. Furthermore, studies have been conducted on policy implementation in particular which see policy development and implementation process as a ‘top-down’ issue of fidelity to policy makers and policy goals without changing much or as a ‘bottom-up’ issue of adaptation of policy as it is being implemented based on context [15].

HIV counsellors are an essential part of the health system in Zambia and are responsible for implementing HIV counselling and testing guidelines within health care facilities. Documenting their challenges and learning from their experiences is important for current and future health related HIV policy reforms in Zambia. Difficult working conditions may pose a challenge to implementers and may force them to develop mechanisms to cope with those challenges as in providing their service to citizens [16]. Yet, it is not clear how the challenges impact the practice and roll out of policy implementation.

In Zambia, the challenges that have been documented to affect health workers in health facilities include inadequate human resources [17], poor and insufficient training [18] and underfunded public health. The government often takes a proactive role in developing solutions to meet such challenges including task shifting [19]. However, it is not clear in Zambia whether health workers have developed their own innovations to cope with the challenges. Nor have the impact of their innovations, if any, on policy implementation been thoroughly investigated. Through exploring the experiences of the counsellors, this study assessed what challenges impacted HIV counsellors in implementing HCT policies and what mechanisms they developed to cope with such challenges.

Lipsky's work has attracted much attention from other researchers interested in the concept of discretion in policy implementation. Much of the literature relates to the appreciation of discretion in terms of its significance for the effectiveness and legitimacy of public policies [15]. There is still a gap in the literature that examines how coping mechanisms developed by frontline workers affect their implementation of policy and consequently policy goals.

## **STUDY PURPOSE**

This was a descriptive case study that sought to understand the role of Counsellors based in urban primary health clinics in implementing HIV counselling and testing (HCT) guidelines

introduced in Zambia in 2006. It sought to answer the basic question: what coping mechanisms, if any did Counsellors develop and how did they affect implementation of the HCT policy? The study looked at the work environments of the Counsellors, what impacted their implementation and what coping mechanisms they developed using their discretion. As a study that was both explorative and descriptive, it sought to answer the ‘how’ question and provided insights around how health workers impact implementation of HCT policy.

## **METHODS**

The study used qualitative methods to explore how HIV counsellors implemented the counselling guidelines for HIV. This is because this methodological approach would help to unravel the answers to the ‘how and why’ questions as well as generate in-depth insight into the experiences of the participants. The study investigated the phenomenon of inquiry in clinic settings through assessing HIV counsellors’ daily interaction with the policy in question. The research design planned to capture HIV counsellors’ understandings of HCT guidelines and other national health policies, as well as their work settings. This provided an opportunity to study their experiences in relation to the clinic environment where Counsellors implemented HCT guidelines. Because the study was investigating what the Counsellors were implementing as well as their perspectives and perceptions about policy implementation, multiple data sources were employed. These included interviews with facility managers, district health personnel and other policy makers. The use of multiple data sources also helped to ensure rigour of the study as findings of the multiple sources were triangulated.

### *Study Population*

The study population included 28 urban health centers owned by the government in Lusaka Province. It was conducted in Lusaka because the province, and specifically the urban areas, have the highest HIV rates in the country. While HIV is highest in the urbanized province of Lusaka, rural provinces such as the Northern Province have the lowest HIV rates with an HIV

prevalence of 8% for northern and 20.8 for Lusaka [20]. The high rates of HIV in Lusaka are also accompanied by greater HIV counselling and Testing services. Lusaka has the highest number of HCT services offered in both public and private health facilities [21].

### *Profile of HIV Counsellors*

Below is a table indicating the training background and employment history and status of the HIV counsellors interviewed:

<b>Counsellor</b>	<b>Yrs of Service</b>	<b>Training Duration and Institution</b>	<b>Employer</b>	<b>Motivation</b>
1	7	1 year by government institution	Government	Intent to serve
2	4	3 months, private	Government	Job security
3	16	1 year government	Government	Intent to serve
4	4 years	1 month, private	Government	Job security
5	3 years	3 months, private	Government	Intent to serve
6	3 years		Government	Job security
7	3 years	1 month, private	Government	Job security
8	12 years	3 years, government, Dip	Government	Job security
9	3 years	3 Weeks, private	Government	
10	12 years	6 months, private	NGO	Intent to serve
11	4 years	3 months, private	Government	Job security
12	6 years	1 year, government	Government	Intent to serve
13	3 years		Government	Job security
14			Government	Intent to serve
15	4 Years	2 weeks, private	Government	

### *Data collection and Sampling*

The target was to include all 28 urban health centers owned by the Government of the Republic of Zambia in Lusaka district bearing in mind the principle of saturation. Saturation was reached after conducting interviews in 15 centers. The HIV counsellors were sampled purposively based



on the following inclusion criteria (i) 1 year's experience at the particular facility and their self-reported familiarity with the facility; and (ii) their presupposed knowledge of the HCT policy guidelines. The study included a convenient sample of one HIV counsellor from each of the 15 urban health centers. The first author recruited participants based on their availability and willingness to participate. Each participant was given information sheets and informed consent forms that they had to sign to document they consented to the study. In addition, a convenient sample of 10 facilities was selected and 10 facility managers were interviewed one from each of the 10 facilities out of a possible 15 facilities. The 10 facility managers were selected by looking at the ones that the researcher went to first and their willingness to participate.

Data was collected using in-depth interviews with all participants (n=31), observation of facilities (n=15) and document reviews. The first author studied documents that were referred to during interviews with participants as well as other guidelines developed by the Zambia Counselling Council. The first author also used a research journal to record his reflections after every day's data collections. The first author developed three interview guides based on the objectives of the study. The guides were for HIV counsellors, policy makers and health center/facility managers. After the initial development of the guides, they were shared with the co-authors who provided their input and had them revised accordingly. The interviews were recorded on a digital recorder and observation notes were recorded in the researcher's journal, which were then used in the analysis. The interviews required more probing and although there was an interview guide prepared, the interviews were as in-depth as possible, with the researcher following up on some responses. On average, 40 minutes was spent on each Counsellor's interviews and 25 on facility managers and the policy-makers.

#### *Data Analysis and interpretation*

Using thematic analysis, the first author used the theory of Street-Level Bureaucrats (SLB) and the assumptions to identify codes and themes. Thematic analysis reveals prominent themes in a text at different levels and provides a rich, detailed and holistic account of the data [22-23].

*Priori codes* were derived from the SLB theory and written manually into a codebook. During data analysis a couple of *emergent codes* were identified through an application called HyperRESEARCH. The coding framework is attached in annexes. The Software enables coding and retrieval of source material, theory building, and analyses of data. With its multimedia capabilities, HyperRESEARCH allows one to work with text, graphics, audio, and video sources.

### *Ethical Considerations*

Ethical clearance from the ethics committee at university of Cape Town Human Sciences Research Council as well as from the research ethics committee at the University of Zambia was received. In addition, permission and consent from the Government of Zambia through the Ministry of Health's Permanent Secretary and the Ministry of Community Development, Mother and Child Health was obtained in order to conduct the research in health facilities. Written consent was obtained from all the informants and the participants were informed that their participations in the study was on a voluntary basis and that they were free to withdraw at any time without penalty.

Participants were provided with an opportunity for questioning after each interview, and were provided with contact details of the primary researcher should they have concerns following the interviews. Anonymity and confidentiality was secured by keeping transcripts in secure folders locked by passwords only accessible to the researcher. Changing participant names to pseudonyms, and ensuring that the interview transcripts were only available to the research team. There were no direct benefits to the participants. The only risk of possible distress was communicated to participants. Fortunately none of the participants demonstrated any psychological distress as a result of the interviews.

### *Theoretical framework*

This study made use of the theory of Street Level Bureaucrats (SLB) to better understand and describe the experiences of counsellors in implementing the HIV counselling and testing

guidelines. Lipsky [24] defines street level bureaucrats as those individuals who work in public agencies such as schools, hospitals, police and the legal service offices. They interact with and have wide discretion over the dispensation of benefits or allocation of public sanctions. The theory was originally published in 1980 by Lipsky who made two distinct claims: The first claim was that the exercise of discretion was a critical component of work that most street level bureaucrats do as they regularly interact with citizens. He also added that the general lack of time, information and resources needed to properly respond to individual cases made it difficult for street level bureaucrats to do the jobs to the highest standards of decision-making.

In order to cope with such complexities, Lipsky argued that street level bureaucrats develop some routines of practice aimed at simplifying their environments in ways that strongly influence the outcomes of their efforts [24]. Examples of such practices include mass processing of clients, which has important implications on the quality of treatment and health services [24].

The second claim was that work though diverse between street level bureaucrats, could essentially be similar in structure and easily comparable. But for the purpose of this study, the first author focused on the first claim as it was the basic question of enquiry and out of it developed some research questions:

- iv. What **motivated** counsellors to enter public service and take up their roles as HCT counsellors?
- v. What kind of **environment** do HCT Counsellors work and what challenges do they face in their work as they implement the HCT guidelines
- vi. Do counsellors have any **coping mechanisms** to cope with the challenges in implementing the HCT guidelines, what mechanisms are these?

## **FINDINGS**

### **Motivation to enter public service**

Lipsky [16] depicted front-line workers as having good intentions to serve as they enter public service [25]. Thus, it was assumed that the HIV counsellors enter public service with an intention to serve. In understanding the HIV counsellors' initial motivations for joining the public service, three types of motives emerged as critical for HIV counsellors' initial intentions to work in the public service: these were rational motives, norm-based and affective motives [ 36]

### *Job Security (Rational Motives)*

The first was the perception that the public service offered better stability and job security. HIV counsellors who stated job security as their motivation to enter public safety also mentioned the ability to access credit facilities like loans as one of the perks of working for the government.

*It was the first time that government was employing Counsellors...I joined because of job security... there is no need to sign contracts all the time*

**-Counsellor-**

*Some of counsellors we have are not adequately trained and were half-baked. Some of them find jobs out of connections from relatives, not on merit, some have done trainings for as low as 3 days*

**- Counsellor (NGO)-**

The study revealed that three HIV counsellors, who said they were inspired by the job security and stability in public service, were in fact those that had been recruited by the government in 2009 as the first group of government paid psychosocial HIV Counsellors. Most of these did not have prior HIV counselling experience and had shorter counselling training. However, as per government requirements, they had a minimum of a diploma in social work.

*I used to be teacher at a private school but there was no job security, so when I heard that the government was recruiting Counsellors with social work qualifications, I did training in counselling for 2 weeks and applied.*

**-Counsellor-**

*Compassion and Passion (Affective/Norm-based motives)*

Another emerging theme around the intention to serve was compassion and passion for disadvantaged people and those living with HIV. There were a significant number (11) of HIV counsellors who shared that their reasons for joining the public service had more to do with their passion to reach out to the poor and contribute to touching lives. They saw the public service as an opportunity to reach as many people as possible in different communities because of the breadth of the catchment areas of public facilities.

*As a person living with HIV, I just wanted to help other people out there so that they cannot make the same mistakes I made*

**-Counsellor-**

*I have always had a passion to serve especially the poor. And I knew that the public service would be the best place because a lot of poor people can't afford private health care...*

**-Counsellor-**

After asking participants whether their initial perceptions about the public sector had changed, most said they had remained the same. Those who admitted to no longer holding their initial perceptions said these changed because of the challenges they found in the public sector. Mostly, it was those who had joined because of job security and financial stability that expressed a disappointing variance between what they expected and what they found in the public service.

*Hey, I thought it would be easier for me in public service, but no..The pay is little and the work is just too much...I am leaving as soon as I get something better*

**-Counsellor-**

HIV counsellors, who said they were inspired by their passion for service, reported to face what they had expected in terms of the pressure at work and thus did not express the same level of disappointment or changes in perception. However, this did not stop them from complaining of the pressure that they faced on a daily basis. Others demonstrated a sense of frustration that most of the problems they were facing were beyond their control and that there were no immediate solutions. Both Counsellors and facility managers admitted that they did not have enough space for the HIV counsellors and their clients. But they also knew that no additional counselling rooms were going to be built in the foreseeable future. This forced them to accept the state of affairs but they nonetheless expressed their concerns and worries.

*But these problems like space; there is nothing we can do about it...we just have to work with what we have. It's not like the government can come and build more rooms (laughs) –*

**Counsellor-**

### **Management and Support of Counsellors**

Lipsky's thesis about the dilemmas of the individual in public services, framed in the idea of "street-level bureaucrats" [16], presents much insight into understanding policy implementation in a number of social scientific fields. One of the key elements of Lipsky's work is how he portrays front-line workers in public service. He presents their human dilemmas without criticism and brings attention to the difficult work environments or conditions in which they typically find themselves while implementing policy. Studying the environments in which the HIV counsellors were working tested Lipsky's assertion that all street-level bureaucrats work in similar settings and conditions.

The first author took time to observe each facility and also discussed the business of the facility with both the HIV counsellor and the facility manager. Through observation, it was clear that all facilities were crowded with the majority of clients waiting for HIV services on the queues. In one facility, a client complained that she had been waiting for 5 hours in order to be seen by an HIV Counsellor. Some Counsellors also mentioned that there were often many people who waited to be seen and get agitated by Counsellors' inability to see them within a reasonable time.

*Sometimes we have people who end up insulting us, especially when we have too many cases, like on days when people come for collection of drugs...but we understand that that's the nature of our job.*

**- Counsellor-**

HIV testing, collection of drugs and counselling was said to make up most of the HIV services that facilities were offering. On average, an HIV counsellor reported to see about 15-25 clients in one-on-one counselling sessions. However, if group-counselling sessions were held, each HIV counsellor could see more than 45 clients a day.

*The Counsellors are stressed sometimes ...if we don't have trainee Counsellors they have to deal with the pressure and that may end up compromising the quality of their services*

**- Sister-in-charge-**

The statements above show the extent of the pressure that most public servants face in a health facility setting. Like Lipsky's assumption, HIV counsellors work under difficult conditions with fewer resources at their disposal. The study confirmed Lipsky's assumptions as the environment in which HIV counsellors worked were visibly under resourced, some buildings were dilapidated, had had stock out of reagents, and slips needed for writing down the results of HIV tests for clients.

*We rarely run out of testing kits, but this one time last year we had a stock-out for months...we had to send people away ... it was one of my worst times as a Counsellor, knowing that even other clinics didn't have the kits and I am sending people away*

**-Counsellor-**

One of the key areas of discussion during the interviews was regarding an average working day for the HIV counsellors. HIV counsellors were asked to narrate what a normal day at the clinic would look like. For the most part, they worked longer hours than what they were supposed to. Others skipped their lunch breaks because the demand for their services was overwhelming.

*If the Counsellors were lucky, they would have some trainee Counsellors who would assist in managing the clients. But even then, there would still be challenges with space.*

**-Sister-in-Charge-**

*We have four student Counsellors who come on certain days of the week. At least when they are here our workload is reduced*

**-Counsellor-**

There were three types of clients that Counsellors gave the services to. The first and most frequent was diagnostic counselling and testing. Clients who came for diagnostic counselling and testing were referred to the HIV counsellors from medical professionals including doctor or clinical officers. Pregnant mothers who came for antenatal care fell in the category of diagnostic counselling and testing clients. To a greater extent, diagnostic counselling and testing clients were considered a priority for HCT because they needed to get back to the doctor for further assistance.

*“When a client is sent to us from the doctor, then we know that we have to attend to that client faster, sometimes they could be very ill, and sometimes the doctor needs to leave so we have to send them back soonest”*



**-Counsellor-**

The second group was those that came voluntarily to test for HIV. These often needed less time for counselling and were advised to ensure that they have ample time to wait in case of a high numbers of diagnostic counselling and testing clients.

*“We just tell those for VCT to say, you have to plan and allocate enough time to VCT, so if they are not ready they should come back when they have time. It is better that way”*

**-Counsellor-**

The last group was those that came for adherence counselling. These would be people who knew their HIV status already and came for counselling on adhering to ARV treatment. This was not considered as urgent should there be a need to prioritize clients.

It was clear that despite working from different clinics, all HIV counsellors faced similar challenges in implementing the HCT guidelines. Some participants appreciated the opportunity to share their concerns and challenges:

*“I hope your report will be shared with government officials so that they can have an idea of what we are going through”*

Asked about their channel of grievance communication, most said they had quarterly meetings with other HIV counsellors at the district level. Some participants met with facility managers or respective heads of counselling on a regular basis. Even facility managers attested to the fact that HIV counsellors do approach them when they have issues that cannot be solved by the counsellors themselves.

*There are some cases that come up and the Counsellors would call me to assist...an example is when there was a man who could not accept his HIV results because the wife was negative*

*-Sister-in-charge-*

*One time a couple came in, the man had been on treatment and was hiding from his wife, helater discovered that she too was coming here for ART. He was very mad and brought his wife with him...Counsellors could not manage the case so I came in to help them, we do that often,*

*-Sister-in-charge-*

The above quotes shows that in some facilities, there was a support system for the HIV counsellors when they faced challenges in their daily operations. In some, there was a disconnection between facility management and the HIV ounsellers.

As stated earlier, 12 out of the 15 the clinics visited had not less than a hundred people waiting to be seen. HIV counsellors insisted that close to half of those would be waiting for HCT or ART treatment, both services which are provided by the HIV counsellors. With an average of 2 Counsellors per clinic, it was difficult for HIV counsellors to attend to all clients in a timely manner. A couple of HIV counsellors noted this:

*Sometimes you find that I have to counsel those for VCT, then I have to counsel those for DCT and run off to ART department to counsel people for adherence.*

*There are also times when we do community rounds. It means that day we will be required to go to the communities and counsel and test people.*

*-Counsellor-*

The demand for services rendered by the Counsellors is similar to what Lipsky noted in his literature.

*The government may sometimes not understand the gravity of our work. We deal with so much psychological issues, not just for clients but also for us. They need to factor this in as they hire more people.*

**-Counsellor-**

Counsellors often reported dealing with rude clients, who seldom understand the pressure that HIV counsellors go through. When there are long queues or fewer HIV counsellors, clients were said to vent to the HIV counsellors and accused them of not being professional. The narratives from both Counsellors and facility managers highlighted this as a challenge that put pressure on HIV counsellors. Another conduct from clients that was highlighted as a challenge was clients' failure to accept HIV positive results.

*“When a client refuses to believe the HIV test results it becomes difficult to deal with. This is not something you learn at school or you may find in guidelines. So it is very difficult to handle”*

**-Counsellor-**

*I once tested someone who came out positive. She literally refused to accept the results because she said she was faithful to a faithful partner...I had to ask the sister-in-charge to come and assist me because the person didn't believe that I was right in my test.*

**-Counsellor-**

### *Interaction with the HCT Policy*

Another factor affecting discretion was the knowledge of the HCT policy. Although all HIV counsellors knew of the existence of the HCT guidelines developed by the Ministry of Health, the majority admitted that they seldom used them in their work. In fact, they demonstrated little knowledge of the content covered in the guidelines. Despite the lack of knowledge of the HCT guidelines, the HIV counsellors reiterated the importance of such guidelines and believed that they were essential in ensuring quality delivery of HIV services.

*It is very good for our work that we have the guidelines...we have them somewhere on the shelf,  
but to be honest I have never taken time to read them*

***-Counsellor-***

It was interesting to note, that although the HIV counsellors were not conversant with the guidelines, they were strongly aware of good practices for HCT in general. Moreover, what they believed to be standard operating procedures were some of the key elements of the HCT guidelines. As such, the HIV counsellors' inadequate knowledge of the HCT guidelines did not hinder the researcher from investigating their experiences with HCT and their familiarity with general good counselling practices.

On the other hand, the facility managers seemed to assume that since the guidelines existed and that copies were at the facility, the HIV counsellors were using them. Facility managers and policy makers also thought that the HIV counsellors were taught about the guidelines in their training, and that they were well aware of what they are supposed to do.

*On HIV and AIDS at least they (Counsellors) have the guidelines and the books in there...they  
do their work according to the guidelines*

***-DHMT Respondent-***

With such assumptions from facility managers, there was no system in place that monitored whether HIV counsellors were following the guidelines, or what counselling guidelines they had access to. Lack of a system in place compromised the quality of service that HIV counsellors offered. As seen in the findings, HIV counsellors had reduced the amount of time spent on clients and sometimes they did not offer confidential individual HIV pre-test counselling. The monitoring that was found was for statistics purposes; such as how many clients the HIV counsellor had seen in a day, week or month. There was however an element of the guidelines

that both HIV counsellors and their managers seemed to be very serious about. These were testing specific guidelines and procedures, namely the testing algorithms. In all the facilities, the algorithms were observed and displayed on the walls offering guidance on how to read the HIV test results, what testing kit to use and when.

### **Inadequate Resources**

The study found exactly the scenario that Lipsky had painted in terms of resourced at the disposal of the frontline workers. His argument was that these workers often work in resource-constrained environment with inadequate resources to do their jobs. This seems to be common sense because every public service in poor counties like Zambia is not spared from the challenge of inadequate resources.

### *Inadequate Space*

According to the HCT guidelines and standard operating procedures for HIV counsellors, counselling is supposed to be done in a private room free from disturbances and should only have the client and the Counsellor present for confidentiality and privacy purposed. The study revealed that in all clinics, there was inadequate space for clients to conduct their sessions. This challenge was two-fold as in some cases were there were too many clients but the space was not enough to deal with the demand. In other cases, there were enough HIV counsellors but not enough space for them to conduct private sessions.

*I can say that the first challenge, as you have seen is space. We don't have enough space to do our counselling from so sometimes we have me and my colleagues sit in one room doing counselling with a client.*

**-Counsellor-**

The problem of space is one that was retaliated by all participants including policy makers who said that they had received a number of reports for the need to have more space. One staff member at DHMT said:

*The issue of space is one that the government is taking seriously; we are in the process of ensuring that health structures are developed to meet the demand of their population especially first level clinics because they have a bigger catchment.*

### *Organisational expectations*

Contrary to Lipsky's assumptions that frontline workers often face a challenge of vague or conflicting organisational expectations, the HIV counsellors knew what was expected of them from their managers. Whether or not these expectations were in line with the HCT policy is another question. However, all the HIV counsellors and their managers had clear expectations ranging from following the 3Cs of counselling (Confidential, Counselling and Consent) to meeting numerical targets like an x number of clients to be seen in a certain period of time. Despite them not having a clear job description, HIV counsellors knew what they had to do by the end of the day and there was less interference from their managers.

### **Performance Measurement**

There were no systems for performance measurement in 12 of the 15 clinics. The HIV counsellors worked based on the demand for their services. The other 3 clinics had numerical targets in place of how many people HIV counsellors were supposed to attend to. The three clinics with targets were those that had relatively fewer clients seeking HIV counselling and testing services. As such, the facility was tasked to proactively encourage people to go and test for HIV.

*In a month we are expected to reach about 500 people with VCT. This is because we are not just funded by the government but by CIDRZ. So we have to meet those targets*

***-Counsellor-***

All three had rigorous outreach programmes for HIV counselling and testing. The majority of the clinics were already overcrowded in themselves and thus no targets seemed necessary. Because this was not a study to investigate the performance of the HIV counsellors, the variable was only used to understand the degree of freedom from management and discretion that HIV counsellors had.

### *Negative attitudes from other staff*

One challenge that was echoed in more than half of the facilities was the negative attitudes/reception from nurses to HIV counsellors. The HIV counsellors and some managers saw this as a result of the fact that nurses used to do the HIV testing before HIV counsellors came, who had taken over their former roles. Some Counsellors claimed that nurses were unhappy because they were receiving similar pay to HIV counsellors despite the fact that nurses spent more time to acquire their academic qualifications.

*Now it is even better, when we came nurses wouldn't take us seriously. Sometimes they would send us to go and file documents in the filing room"*

***-Counsellor-***

*We have received some complaints from the Counsellors of how they are being treated by professionals. But it's understandable because the Counsellors only spent a few weeks in training while nurses spent 3 years."*

***-Sister-in-Charge-***

While there were some HIV counsellors who reported to not care about how they were treated by nurses, some found the attitudes from nurses frustrating and shared how they felt compelled to prove their relevance at the facility. HIV counsellors also said that they did not receive enough consideration from the nurses and even some facility managers

*I have tried to be nice to them (nurses) but sometimes its just tough mwandi..bamabwela so olo baona ati nili mu session, bazangena no noking'a even when ninshi nili na client (Sometimes nurses come when I have a session, they will just enter without knocking even when I have a client)*

**-Counsellor-**

*We don't work with doctors, but i don't think they are not a problem, but nurses, they are a problem, to them we are just useless, there is no respect, you would be having a session, they would just walk in, do their work, leave the room, some times even leave the door open.*

**-Counsellor-**

*Like when there are some benefits like let's say allowances, management will produce a list and stick it with names of those who will receive first. When we ask why our names are not there, they will tell us that we have to wait for professionals to receive first*

**-Counsellor-**

### **Discretion**

It was apparent in the interviews that all Counsellors exercised discretion in their roles while implementing the HCT policy. The fundamental factor that implied HIV counsellors' discretion was the lack of job descriptions. All the 15 Counsellors and 10 facility managers were aware of general roles and responsibilities of the HIV counsellors. However none of the HIV counsellors reported to having proper job descriptions. Targets set by management guided the work of 3 HIV counsellors. For instance, on how many clients they had to test in a month. One HIV counsellor when asked how she knew that what she was doing was correct responded:

*I use what I was taught in counselling school, like how to treat my clients, what to do when confronted by various situations.*

And another Counsellor said:



*I cannot say we have job descriptions but all of us know what we are supposed to do and we try to apply that to the best of our ability.*

Both facility managers and policy makers at the ministry validated this information. All of them alluded to the fact that there was some form of common understanding of what HIV counsellors needed to in the place of work.

Although discretion was obvious across all counsellors, the degree of that discretion varied from case to case. In seven out of fifteen facilities, counsellors were under direct supervision of their facility managers. These managers had other clinic staff that they supervised and thus their meetings with the counsellors were rather occasional. On the other hand, in the remaining eight clinics, counsellors had immediate supervisors with the HIV unit who were senior counsellors. They therefore had more frequent meetings and supervisory contact. The degree between these two categorized was somewhat different.

As one counsellor supervised by a facility manager stated:

*I know I am suppose to report to the sister-in-charge who manages the clinic, but because she is so busy I have to work with minimal supervision*

*I am a senior supervisor, and every week I meet with the counsellors to check-in with them and see how things are going...are they facing any challenges and so on*

***Counsellor Supervisor***

## **Coping Mechanisms**

### ***Rationing***

There didn't seem to be any apparent or implied rationing of resources by counsellors. In fact, all counsellors said they attended to their clients on the first come first served basis, save for those

referred to them by doctors for diagnostic counselling and testing. Although not rationing the resources they had like, testing kits, HIV counsellors seemed to ration their time. According to HCT guidelines, ample time had to be spent on one client to ensure that they understood and had enough time to ask questions about HIV and the test. The guidelines had recommended 45 minutes for a single one-on-one session. Generally, counsellors were aware for the recommended time. However, due to the large numbers of clients they had to reduce n the time spent. On average, each session lasted between 10-15 minutes for individual sessions and 20 minutes for group sessions.

*We leave out most of the things, due to high numbers; time is a big challenge in terms of following guideline policies. Every time we go to DHMT, we present this challenge every time, may be in future they will consider changing or making amends.*

**-Counsellor-**

*If we are giving a post or pre test we won't do it according to the guidelines. ...so we would even make a short-cut called diagnostic HIV counselling were we do not go so much into detailed counselling, we just test...*

**-Counsellor-**

The HIV counsellors had to ensure that they attend to at least everyone who comes for the service, and one way they found to be effective is rationing their time.

### *Group education in place of individual counselling*

HIV counsellors and their supervisors resorted to having what they termed 'group counselling'. This is where they would invite a group of 15-45 clients at the same time and gave pre-test information about HIV. What the HIV counsellors called group pre-test counselling was in fact merely awareness event. The first author attended 3 of such meetings both of which were teaching people about hygiene, prevention of STIs, the need to test for HIV and ART. In such

groups, it was said to be difficult for HIV counsellors to address personal issues and problems that some clients would want to be addressed before they tested like sexual history.

*“Sometimes we have 30 maybe 40 people in one group...we do the group counselling only for pre-test, then we test them individually and after that we do individual post-test counselling and give results”*

**- Counsellor-**

*We prefer to go for group HIV counselling secession looking at the number of clients that we see, then after that the clients are explained on what is expected, especially on the issue of results then that is when they go for post counselling testing which is done one-on-one*

**-Counsellor-**

### *Using counselling ‘unfriendly’ rooms*

For 9 of the 15 clinics, the counselling rooms were also the offices for the HIV counsellors. As such, at any given time there were at least two HIV counsellors sharing an office even when sessions were in progress. During one visit, the first author found the HIV counsellor conducting a session in the presence of another HIV counsellor who was doing his own deskwork. When asked why that was so, the HIV counsellor responded saying:

*They (Counsellors) may want to carry out private test but it won’t be possible because there is no other room for such. We only have one room for Counsellors, for the pre and post-test, there is great need for privacy, so we have to make do with the space we have*

**-Sister-in-charge-**

To cope with inadequate space and counselling rooms, HIV counsellors had to disregard some requirements for a professional private and confidential counselling room as per HCT guidelines. This was a real case of biased practices by health workers to fulfill the expectations and demands to provide HCT amid infrastructural constraints.

### *Coping with Stock-outs*

While nearly all HIV counsellors recounted the one time that the clinics ran out of reagents needed to carry out an HIV test, majority of them said they did nothing to prevent the stock-outs or ration the commodity. They conducted their sessions normally and waited until they ran out of reagents. Lipsky's theory would have claimed that in preventing stock-outs, street-level bureaucrats would devise criteria that would enable them ration their stock-outs. An example would be not informing citizens of the existence of the HCT services [16]. However, out of the 15 HIV counsellors in the 15 clinics, only two said they had prioritized some clients based on the way they appeared, whether seriously ill or not.

### *Coping with daily pressure*

Facility managers and policy makers admitted that there were no debriefing policies for HIV counsellors within their facilities. Thus, although the HIV counsellors worked in very busy environments and had to deal with difficult cases, there was no system in place for their own psychological support. Some HIV counsellors utilized their personal relationships with their facility managers to seek advice on different cases and try to cope with their stressful jobs and the pressure that comes with it.

*We don't have any guidelines on debriefing...it is important for Counsellors to have time to reflect and we have tried to ensure that they have monthly meetings and quarterly ones at the district level*

### **-Policy maker- DHMT**

According to HIV counsellors, the monthly and quarterly meetings were not a space for addressing their emotional and psychological needs as a result of their job but that they were mainly discussions on performance and results.

## **DISCUSSION**

Although the sample was not representative of the entire country, it shed light on the

perspectives of health care workers in Lusaka. The in-depth conversations with independent 15 generated collaborative insights, which enhanced confidence of having reached data saturation. Moreover, the aim of qualitative research is not to be statistically representative but to generate rich insights around a particular phenomenon. The in-depth nature and rigorous design of the study provided plausible and relevant insights into the experiences of health workers/street level bureaucrats as framed by Lipsky [16] when implementing policy. Further, the HIV counsellors' responses were triangulated by interviews with facility managers. The findings are also consistent with related research in this area on challenges of health workers [26-29]; which also found that frontline workers have to develop coping mechanisms that are in most cases divergent from policy goals [34].

Further, the findings of the study confirm the assumptions that Lipsky made in his book (1980) as well as the value of comparing diverse HIV counsellors experiences and jobs, like any other frontline workers, across separate clinics. The HIV counsellors' narratives were similar in a number of ways including inspirations for being in public service; challenges faced and developed coping mechanisms. The profile of counsellors showed that the majority of them had started counselling almost at the same time. What was interesting to note is that this was time when government conducted a mass recruitment for HIV counsellors and testing. In that case it explains why the same HIV counsellors who joined maybe 3-4 years prior spent fewer time in training as opposed to those who had served longer years. The impact of less training and the circumstances of recruitment were also reflected in their motivation for taking up employment as government HIV counsellors.

### *Knowledge of HCT Policy*

The fact that the HIV counsellors were not using the guidelines was a cause for concern at the start of the study. However, it was discovered that what HIV counsellors were implementing was in line with the formal HCT guidelines, even without the HIV counsellors knowing so. The policy was thus put in the hands of front level workers and its implementation was dependent on

them. This reveals the power that implementers have in shaping policy and highlights the need for a deliberate bottom-up approach in policy development and agenda setting. This is important in order to make policy more relevant and applied to respective contexts. The study revealed that HIV counsellors were not being involved in any HIV policy development process. When asked if they had been part of any health policy development process, all HIV counsellors said that they had not. Rather most of them indicated that they received orders and decisions from their managers or the district health management team. One HIV counsellor stated:

*Never. We just act on what we are told, like new testing algorithms are out and we don't even know how they were developed.*

Although the claims from government policy makers were that HIV counsellors were involved in the development of the HCT guidelines, no Counsellor in the study reported to be involved. The first author asked HIV counsellors and policy makers whether HIV counsellors were consulted about or knew of the development of the HCT guidelines.

*It was a consultative process where the government brought together a team of technical people including Counsellors to input into the guidelines.*

**-Staff, Ministry of Health-**

In commenting on the HCT policy development process, one Counsellor said:

*We need to have a big role to play in the policies that are going to be revised or brought about...we are the front liners...we understand things better than the policy makers.*

**-Counsellor-**

This discrepancy could have been because of two factors: due to resource constraints, technocrats take up the role of formulating policies with less time to invest in the bottom-up approach of having implementers taking the lead. And the other factor could be that the cadre of

HIV counsellors that is in public service was first recruited in 2009 by the government, that is 3 years after the HCT policy had already been formulated.

### *Resources*

There were no unique findings regarding the resources available for the Counsellors. The situation reflected a common finding in many health settings in the country. The Counsellors maintained very positive attitudes despite having inadequate resources at their disposal. Although one might assume that frontline workers in such resource-constrained settings would be frustrated, the majority of HIV counsellors reported a great sense of gratefulness and prestige. One reason for this could be that some of the HIV counsellors were among the few HIV counsellors who were recruited by the government, and had a related sense of privilege. One private HIV counsellor, who wished to be a government employee, alleged that the recruitment of those HIV counsellors was done unethically and that most HIV counsellors were hired through nepotism. There could be some truth in the allegations considering that 3 HIV counsellors had never practiced counselling before being hired by the government. It would not be accurate to say that nepotism affected implementation of the policy by the HIV counsellors. It did however become a factor in how much prior training an HIV counsellor had before taking up the HIV counselling job as shown in the profile of the counsellors. At the bare minimum, all counsellors seemed to be aware of what due process to follow when providing their service based on prior training.

### **Experiences of Counsellors**

Despite it being more than three decades since its initial conceptualization, Lipsky's work is still useful in understanding behaviours of frontline workers during policy implementation. Firstly, the theory helped the researchers to understand the context and environment of frontline workers through the lens of HIV counsellors in Zambia. It demonstrated that contrary to popular arguments, the combination of freedom from organisational authority and discretion does not always lead to frontline workers 'making policy' in unexpected or unwanted ways. The case of

the HIV counsellors provides a very good example, as they implemented the policy as close to the guidelines as possible. Thus, one can counter schools of thought that attempt to portray discretion as a 'bad' thing for policy.

Secondly, Lipsky argues that most frontline workers enter the public system with good intentions to serve, but inadequate resources and other challenges tends to frustrate and uninspired workers, hindering such intentions. The findings in this study do not support this assertion, as almost every HIV counsellor said they had no regrets for joining and that their motivations for being in the service remained unchanged despite the challenges. While it is accurate to argue that the majority of frontline-workers enter public service with good intentions to serve, it would be inaccurate to argue that their motives and intentions alter as they face challenges such as lack of resources, high demand of their services and unclear or contradicting organisational expectations.

The phenomenon of a frontline worker changing their mind after entering public service depends on a number of factors, and inadequate resources is just one factor. For instance most HIV counsellors, who entered public service with perceived 'good' intentions to serve, admitted to remaining inspired and motivated to do their work. This mainly applied to those whose motives were 'affective' (-patriotism of benevolence and commitment to HIV) and norm-based (a desire to serve the public interest) rather than rational (advocacy for a special or private interest) [36].

Thirdly, organizational expectations were not apparent among the HIV counsellors interviewed. It was clear that most of them set their own expectations outside the fundamental 3 Cs of *Counselling Confidentiality* and *Consent*. Meaning that as long as these 3Cs are upheld, HIV counsellors were meeting their expectations. A lack of detailed and documented organisational expectations could have been as a result of the fact that management had no adequate information regarding the HCT guidelines.



Fourthly, performance measurement, which was viewed (by first author) in respect to how HIV counsellors were being supervised, seemed to be absent in majority of the clinics. Nearly all clinics, with an exception of two had no form of basis to measure the performance of HIV counsellors. This could have been because all clinics in the study had scheduled times for staff meetings to discuss operations and emerging matters. There was thus a risk to think of such meetings as aiding performance measurement. However these meetings were reported to be about needs and aspirations of staff members. In light of this, HIV counsellors' discretion and freedom from organizational management was big. The fact that the majority of the HIV counsellors and their managers did not have any performance measurements in place, coupled with the lack of knowledge of the HCT policies between both parties, contributed to the degree of discretion and freedom for HIV counsellors.

### **Discretion and Coping Mechanisms**

Lipsky sympathized with the challenging environments in which front-line workers work and argued that to deal with such challenges, they typically developed coping mechanisms. The assumption was that HIV counsellors felt overwhelmed by their work and demands such that they ended up developing coping mechanisms [9]. The study confirmed that the HIV counsellors were overwhelmed by their work and often devised routines and innovative ways of dealing with their clients. In order to deal with these challenges, the HIV counsellors developed simple routines. The routines included group counselling instead of individual counseling, open-space counselling instead of in-door, and reduced time spent with clients. These routines were common in all facilities and were validated by both facility managers and policy makers.

Some of the routines developed could have had implications for the quality of service provided. For instance, the HCT guidelines categorically stated that if "group health talks are used, they should be followed by individual pre-test counselling." However, none of the counsellors who used group counselling followed them up with individual pre-test counselling. What they all did was rather test their clients immediately after group counseling. This compromised the readiness

of the client to test for HIV or the ability to accept the test results afterwards. Thus, although group counselling was given as one of the primary ways to deal with the large number of people requiring HCT and unavailability of spaces, it raised serious concerns about the quality of HCT.

### *Discretion*

The aspect of discretion among frontline workers has been a subject of inquiry in policy implementation. Lipsky's work and the critique of that work by Howe (1991) tends to portray and treat discretion as an element that is either present or absent and assumes that professional discretion is self-evidently a 'good thing'. There is an alternative argument based on two claims. First, that creating more rules and regulations does not result in control or curtailment of discretion; because more rules tend to lead to frontline workers finding new ways to exercise discretion. And second, discretion as it is known is not necessarily either a good or a bad phenomenon. [37]

In line with the alternative argument, the study took discretion as a series of degrees of freedom to make decisions based on how often counsellors would make decisions without consulting their superiors; and whether they were expected to follow a set of preset routines. Each counsellor portrayed unique degrees of freedom to make decisions in their routine work. Overall, it was easy for the counsellors to exercise discretion because of the lack of job descriptions or frequent supervision from the facility managers. They implemented the policy and conducted their daily routines based on their own understanding of what was expected of them. All the 15 counsellors and the 10 facility managers noted that the most important expectations in their role as counsellors was ensuring that they upheld patient confidentiality and conducted themselves in a professional manner.

The degrees of discretion differed from case to case depending on three factors. Firstly, counsellors who had multiple supervisory meetings with their supervisors were less likely to

exercise discretion compared to those who had less frequent supervision. Secondly, there were some counsellors who were supervised by facility managers and thirdly those who had senior counsellors as their supervisors. The latter consequently had more frequent meetings with their supervisors and carried out their duties based on agreed procedures and in uniformity with other counsellors. HIV counsellors supervised by facility managers had less contact due to the many responsibilities that facility managers had.

Another aspect that contributed to the variation in degree of discretion among the counsellors was the lack knowledge of the HCT policy. In most cases, neither the counsellors nor their managers were aware of what the HCT policy stated. Not knowing what was expected of them according to the HCT guidelines, counsellors had more leeway to do what they believed to be the right thing in their jobs. This reflects that inadequate knowledge of policy coupled with freedom from organisational management increases the degree of discretion. Organisational management in this context referred to supervision, formal expectations or prior agreed tasks and practices.

Lipsky argued that frontline workers have discretion because of the nature of their job and how distant they are from their supervisors. However, supervision of frontline workers in general has evolved tremendously. Supervisors in different institutions have frequent interactions with their juniors. Some have built interpersonal relationships outside work [40]; and the gap between a frontline worker and a senior manager has been filled by new structures like assistants and deputies. For example, the counsellors did not report to senior managers at district or provincial levels. Instead they had local supervisors within the facility. Factors affecting discretion need to be explored further as the study revealed that knowledge of policy (not just of frontline workers, but their supervisors too), frequency of and contact with a supervisor were crucial factors that contributed to the degrees of discretion. These findings are in line with those of Taylor and Josie [38]

## **Coping mechanisms**

The study presented the various coping mechanisms used by counsellors and affirmed the claims by Lipsky concerning the tendency of frontline workers to develop routines that enable them to cope with the challenges in their work. It provided a glimpse into some of the mechanisms and how they may affect policy implementation and compromise service delivery

#### *Rationing the services provided.*

From the self-reports by the counsellors, rationing of the services that they provided was not one of the coping mechanisms. Nor was there any form of criterion used to attend to patients, apart from those clients who were referred to counsellors by their doctors for diagnostic counselling and testing. Prioritizing those clients could not be seen as rationing because counsellors had no control over this. The absence of rationing can also be accounted for by the nature of the services that frontline workers give. The HIV services, falling in the category of essential health services, could have created some ethical dilemmas among counsellors around whether it would be appropriate to ration their services.

As evident in the findings above, most counsellors applied the rule of first come-first served, even when they knew that they would run out of testing reagents used for diagnosing HIV. Although Lipsky argued that all street-level bureaucrats (frontline workers) have similar characteristics because they work in similar environments, there are large differences between frontline workers dependent on their environments.

### **LIMITATIONS AND CHALLENGES**

There was one major challenge during data collection. Some respondents refused to have their voices recorded on a voice recorder because they did not want to be identified, despite the first author assuring them of the highest level of confidentiality. This made it tedious for the researcher to both ask questions and take detailed notes of the responses. Other challenges were minor such as financial constraints that delayed the start of the fieldwork and time constraints including busy health workers who could only spare a limited amount of time. Due to the size of

the study sample, it is not possible to make generalizable claims from its findings. However, it offers rich insights into the commonalities of work environments and settings for most street-level bureaucrats in health institutions. Self-reports were also a limitation of the study as they presented a risk of bias, problems of recall and faulty memory, which may have affected the reliability and validity of the interviews, although this is not a particular disadvantage to this approach only [35].

The study was guided by Lipsky's theory on street level bureaucrats from the onset. The authors acknowledge the fact that this could have been a limitation in that by using this theory as a framework of study and data analysis, some interesting data could have not been captured. This is not a negative thing because the bias to Lipsky's theory was well presented beforehand.

## **CONCLUSIONS AND IMPLICATIONS**

The study set out to explore the experiences of HIV counsellors in implementing the HIV Counselling and Testing Policy in Zambia. It used a theory by Lipsky (16, 24), which described the behaviours of frontline workers also known as 'street-level bureaucrats'. The study found that indeed HIV counsellors were in a sense shaping the HCT policy, yet for some reasons and conditions different from the assertions of Lipsky's theory. The findings demonstrated that discretion is a very complex phenomenon and that the way it is exercised differs depending on the context. In relation to Lipsky assertions, the study proved that frontline workers indeed design policy by exercising discretion and developing routines to make their work easier. Such was the case of the HIV counsellors in Zambia's urban health centers.

This study found that most of what the policy on HIV counselling and testing was, dependent on HIV counsellors prior knowledge from training and their own judgment. Neither HIV counsellors nor their supervisors were strongly conversant with the HCT policy itself. Factors

that affected discretion of Counsellors were the lack of clarified expectations from the facility managers, the inadequate knowledge of the HCT policy by the HIV counsellors and their supervisors, and the infrequent supervisions and performance measurements. Challenges that HIV counsellors faced included high demand for their services, inadequate resources including space and in some cases, too few HIV counsellors to attend to large populations of patients. To cope with these challenges, HIV counsellors cut down on the amount of time spent on individuals, introduced group counselling and ignored some recommendations that they considered ‘unrealistic’ but where in the HCT policy.

Finally, the exercise of discretion was clearly an important aspect of the experience examined. Instead of arguing on whether discretion is important or not, or whether it affects implementation, scholars must shift the discussion to the nuanced and complex nature of discretion including the various factors that contribute to discretion and in turn, affect policy goals. More research needs to look at the interplay of individual values, beliefs and attitudes with the nature of the profession in affecting one’s ability to exercise discretion and to what degree.

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## APPENDIX 1: Information Sheet

Study Title: Exploring experiences of HIV Counsellors towards HIV Counselling and Testing Guidelines  
in Zambia's Public Urban Health Centers

### **What is the University of Cape Town?**

The University of Cape Town is a public institution of higher learning, which, among other things, carries out health research. The kind of research that we intend to carry out is different from treatment, as it does not involve drugs.

### **The purpose of the study**

The purpose of our study is to understand what experiences different stakeholders especially HIV Counsellors have regarding the implementation of HCT policy guidelines. You may know that policy implementers play a very important role in policy because they are the ones who translate policy into action. And people often experience policy through whatever the policy implementers choose to implement. We are thus trying to understand what experiences of Counsellors (implementers) are with the HCT policy, what the intention was from government and the environment in which Counsellors work.

### **Voluntary participation**

You may choose to take part in the study or not, but we would strongly encourage your participation because it is only through your responses that those responsible for health can best know how to deliver better services to you. However, there is no harm in choosing not to participate. Those taking part in the study and would like to withdraw can do so any time in the course of the study. We are neither paying any money nor supplying drugs to participants.

### **Confidentiality and anonymity**

No one other than the researchers and our supervisors will have access to the information we will get from you. Besides, our research records are stored in a locked safe and in computers, which are password protected. Our final report will not have any names such that those participating will remain anonymous to everyone reading the report.

### **Benefits and Risks**

There may not be direct benefits to all individual participants, but there may be future benefits to entire communities if recommendations of the final report are adopted. Overall, your opinions will help in identifying problem areas in health policy formulation and implementation processes. The study is not

likely to pose any risks to the welfare of the participants, however, should there be any psychological distress resulting from the interaction with some participants such as the Counsellors, a referral system for counselling will be employed. This will involve referring the participants that may need counselling to accredited Counsellors with researcher paying for transportation costs for the participant. Consultation fees and any other costs one may incur are the responsibility of the participant.

### **Referral system for Participants**

Some participants might need counselling after psychological distress that comes with talking about both their personal as well as professional experiences in dealing with clients who test positive to HIV. In order to support these, they will be referred to professional Counsellors at the nearest government public counselling center of their choice. A prior arrangement will be made with the Zambia counselling council that will introduce the researcher and his referrals to the member Counsellors within the study area.

### **Who sanctioned research?**

The University of Cape Town Ethics Committee has authorized the research; the University of Zambia Research Committee and the Ministry of Health have also authorized this research. These bodies have scrutinized the study and confirmed that it is necessary, safe and will be carried out as required by ethical guidelines.

### **Contact**

You can ask any questions that you might have by contacting the researcher:

**Investigator:** Remmy M. Shawa  
**Cell:** +27710951997  
**Physical Address:** 8 Anneslie Mews, Derby Road, Kenilworth, Cape Town  
**Email:** [remmyshaw@gmail.com](mailto:remmyshaw@gmail.com)

**Further questions about your rights or welfare in the study maybe directed to the Health Research Ethics Committee on the following details:**

**University of Cape Town, Faculty of Health Sciences**  
Room E52-24 Old Main Building

Groote Schuur Hospital  
Observatory 7925  
Telephone (021) 406 6338  
Email: shuretta.thomas@uct.ac.za

**Or**

The University of Zambia Research Ethics Committee  
Great East Road Main Campus  
Box 32379 Lusaka Zambia

## **APPENDIX 2: CONSENT FORM**

### **Study Title: Exploring experiences of HIV Counsellors towards the HIV Counselling and Testing Policy in Zambia's Public Urban Health Centers**

I, \_\_\_\_\_, have had the research explained to me (or have read through the consent information sheet). I have understood all that has been read and had my questions answered satisfactorily. I understand that I can withdraw from the study at any stage and my withdrawal will not affect health benefits due to me.

#### **Risks and Benefits**

There may not be direct benefits to all individual participants, but there may be future benefits to entire communities if recommendations of the final report are adopted. Overall, your opinions will help in identifying problem areas in health policy formulation and implementation processes. The study is not likely to pose any risks to your welfare, however, should there be any psychological distress resulting from our interaction, a referral system for counselling will be employed. I shall then refer you to a trained, qualified and certified Counsellor from any of the public counselling centers of your choice and will pay for your transportation Consultation fees and any other costs you may incur are your own responsibility.

#### **Referral system for Participants**

As mentioned above, should you need counselling after psychological distress that comes with talking about either your personal or professional experiences in dealing with clients who test positive to HIV, you will be referred to professional Counsellors at the nearest government public counselling center of

your choice. A prior arrangement has been made with the Zambia counselling council that will introduce you to all of their Counsellors within the areas you operate.

**Please tick one where relevant and delete appropriately:**

☐ **Yes**   ☐ **No**   **I agree/ don't agree to take part in this research**

*[If the potential participant says „No“, then terminate the consent process here]*

**Participant's signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Participant's name:** \_\_\_\_\_ **Time** \_\_\_\_\_

(Capital letters only)

I certify that I have followed all the necessary ethical procedures as stipulated in the study for obtaining informed consent.

**Investigator's signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Investigator's name:** REMMY SHAWA M                      **Time** \_\_\_\_\_

(Capital letters only)

#### **Contact**

You can ask any questions that you might have by contacting the researcher:

**Investigator:**                      Remmy M. Shawa

Cell:                                      +27710951997

Physical Address:              8 Anneslie Mews, Derby Road, Kenilworth, Cape Town

Email:                                  [remmyshawa@gmail.com](mailto:remmyshawa@gmail.com)

**Further questions about your rights or welfare in the study maybe directed to the Health Research Ethics Committee on the following details:**

**University of Cape Town, Faculty of Health Sciences**

Room E52-24 Old Main Building

Groote Schuur Hospital

Observatory 7925

Telephone (021) 406 6338

Email: shuretta.thomas@uct.ac.za

**Or**

The University of Zambia Research Ethics Committee

Great East Road Main Campus

Box 32379 Lusaka Zambia

## **APPENDIX 3: INTERVIEW GUIDES**

### **A. In-depth Interviews: HIV Counsellors**

1. How long have you been practicing HIV counselling?
2. Please tell me about your work and what led you to join the public service?
3. In comparison to your intentions to join how have your feelings changed concerning public service?
4. Kindly describe what your normal day is like at work?
5. To what extent is this facility busy when it comes to HIV counselling services?
6. What do you know about the HCT policy?
7. How did you come to know about the HCT policy?
8. Why do you think the policy was introduced?
9. Who do you think was involved in formulating the policy
10. What are your experiences in implementing the HCT policy?
11. How do you find the guidelines in the HCT policy when it comes to you following them
12. What enablers or hindrances have you met in implementing the HCT policy guidelines and how have you worked around that?
13. What are 3 challenges you faced and how did you deal with them in your work?
14. Are there some initiatives you have developed to do your job that are not outlined in the policy? What are those initiatives?
15. In interacting with other Counsellors, do you think they follow the guidelines? What are some of the challenges?
16. What do you understand to be the role of implementers in policy formulation?
17. If you had to change anything about the HCT policy what would that be?



18. What can be the possible role of the facility manager in supporting you as you implement the HCT policy? (Probe the degree of current support)

## **B. Facility Managers**

1. Please describe the facility daily operations in terms of how busy or not busy it is?
2. How would you rate the match between numbers of clients for HIV services and the available Counsellors?
3. Are you conversant with the work of the HIV Counsellors? Please explain how you think they operate
4. What do you know about the HCT policy?
5. How is the performance of the Counsellors monitored or evaluated?
6. What are some of the expectations you have for the Counsellors in terms of their performance?
7. What other policies are Counsellors expected to abide by or implement? (Probe for internal policies)
8. What could be the possible role of facility managers in supporting implementation of the HCT guidelines? (Probe how they support)
9. How would you rate the political will from the district management team in the implementation of the HCT policy?

## **C. DHMT Staff**

1. How were you or your office involved in the development of the HCT policy?
2. How was the process for the development of the process and what stakeholders were involved?
3. Why was the HCT policy developed in the first place?
4. Is there an implementation plan for the HCT policy (probe if none)
5. What are your views regarding the implementation of the HCT policy?

6. How have you been monitoring the implementation of the policy?
7. What are the minimum guidelines that should be followed by the Counsellors?
8. What are the effects of not following the HCT policy guidelines on the clients?
9. How are public health policies formulated?
10. Who has the mandate to monitor and evaluate the HCT policies?
11. Have you received any complains regarding the quality of counselling of the Counsellors?
12. What are the government's plans on reviewing the HCT policy?
13. What do you perceive to be your role in supporting the implementation of the HCT guidelines?
14. What do you think influences the work of HIV Counsellors?

## **APPENDIX 4: UCT ETHICAL APPROVAL**



**UNIVERSITY OF CAPE TOWN**  
**Faculty of Health Sciences**  
**Human Research Ethics Committee**



Room E52-24 Old Main Building  
Groote Schuur Hospital  
Observatory 7925  
Telephone [021] 406 6338 • Facsimile [021] 406 6411  
Email: linsey.samuels@uct.ac.za  
Website: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms)

16 October 2013

**HREC REF: 556/2013**

**Mr R Shawa**  
**c/o Ms E Stern and Prof L Gibson**  
Public Health and Family Medicine  
Falmouth Building

Dear Mr Shawa

**PROJECT TITLE: EXPLORING EXPERIENCES OF HIV COUNSELORS TOWARDS COUNSELLING AND TESTING GUIDELINES IN ZAMBIA'S PUBLIC URBAN HEALTH CENTERS**

Thank you for your letter to the Faculty of Health Sciences Human Research Ethics Committee dated 8<sup>th</sup> October 2013.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

**Approval is granted for one year until the 30<sup>th</sup> October 2014**

- Please add to the Informed Consent document, that it is the Faculty of Health Sciences, Human Research Ethic Committee.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms))

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

**Please quote the HREC. REF in all your correspondence.**

Yours sincerely

**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, FHS HUMAN ETHICS**

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical

HREC 556/2013

## **APPENDIX 5: UNZA ETHICAL APPROVAL**



THE UNIVERSITY OF ZAMBIA  
DIRECTORATE OF RESEARCH AND GRADUATE STUDIES

Telephone: 260-211-280258/293937  
Telefax: 260-211-280258/293937  
E-mail: [drgs@unza.zm](mailto:drgs@unza.zm)  
IRB 00006464  
IORG: 000376

P O BOX 32379  
LUSAKA, ZAMBIA

13<sup>th</sup> November 2013

Mr. Remmy Malama Shawa  
8 Anneslie Mews, Derby Road  
Kenilworth,  
Cape Town

Dear Mr. Shawa

**APPLICATION FOR RENEWAL OF ETHICAL APPROVAL FOR STUDY**

Reference is made to your application for renewal of ethical approval for your study entitled *"Exploring experiences of HIV Counselors toward the HIV Counselling and Testing (HCT) Policy in Zambia's Public Urban Health Centres"*.

I am pleased to inform you that approval has been granted to renew ethical clearance of your study, which is a continuation of a pilot project.

<b>ACTION:</b>	<b>APPROVED</b>
<b>DECISION DATE:</b>	<b>NOVEMBER 2013</b>
<b>EXPIRATION DATE:</b>	<b>NOVEMBER 2014</b>

Please note that you must also obtain written authority from the Permanent Secretary, Ministry of Health before conducting your research. The address for Permanent Secretary, Ministry of Health, Ndeke House, P O Box 30205, Lusaka: Tel+260-211-253040/5 Fax: +260-211-253344.

Finally, please also note that you are expected to submit to the Directorate of Research and Graduate Studies a Progress Report and a copy of the full report on completion of the project.

Dr. Augustus Kapungwe  
**CHAIRPERSON, HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE**

Cc     Director, Directorate of Research and Graduate Studies  
         Assistant Director, Directorate of Research and Graduate Studies  
         Assistant Registrar (Research), Directorate of Research and Graduate Studies

## **APPENDIX 6: MINISTRY OF HEALTH ETHICAL APPROVAL-ZAMBIA**

Correspondence should be addressed to the  
Permanent Secretary

Phone: +260 211 253040/5  
+260 211 253344



REPUBLIC OF ZAMBIA  
**MINISTRY OF HEALTH**

*In reply please quote:*

**MH/101/17/6**

NDEKE HOUSE  
P. O. BOX 30205  
LUSAKA

9<sup>th</sup> December 2013

Mr Remmy Malama Shawa  
8 Anneslie Mews, Derby Road  
Kenilworth, Cape Town,  
SOUTH AFRICA.

Dear Mr Shawa

**Re: Request for Authority to Conduct Research**

The Ministry of Health is in receipt of your request for authority to conduct research entitled  
"Exploring Experiences of HIV Counsellors toward the HIV Counselling and Testing  
(HCT) Policy in Zambia's Public Urban Health Centres". I wish to inform you that following  
submission of your research proposal to my Ministry, our review of the same and in view of the  
ethical clearance, my Ministry has granted you authority to carry out the study on condition that:

1. The relevant Provincial and District Directors of Health where the study is being conducted are fully appraised;
2. Progress updates are provided to MoH quarterly from the date of commencement of the study;
3. The final study report is cleared by the MoH before any publication or dissemination within or outside the country;
4. After clearance for publication or dissemination by the MoH, the final study report is shared with all relevant Provincial and District Directors of Health where the study was being conducted, and all key respondents.

Yours sincerely,

Dr. P. Mwaba  
Permanent Secretary  
**MINISTRY OF HEALTH**  
Cc: District Medical Officer





## APPENDIX 7: SAMPLING LIST

Respondents	Sample
Counsellors	15
Facility Managers	10
Policy staff	6
<b>Total</b>	<b>31</b>

ORGANISATION	RESPONDENTS
Ministry of Health	2
Zambia Counselling Council	1
National AIDS Council	1
Ministry of Comm. Dev	2
<b>Total</b>	<b>6</b>

NO.	NAME OF CLINIC	HIV Counsellor	Facility Manager/Sister-in-Charge	Facility Observations
1	Bauleni	X	X	
2	Chainama			
3	Chainda	X		X
4	Chaisa	X	X	
5	Chawama			
6	Chazanga			
7	Chelstone	X	X	
8	Chilenje			
9	Chipata	X	X	
10	Civic Centre			
11	Chunga	X	X	
12	Evelyn Hone College			
13	Kabwata	X		X
14	Kalingalinga			
15	Kamwala	X	X	
16	Kanyama			
17	Kaunda Square			
18	Lilanda	X	X	
19	Lusaka Central Prison	X		X
20	Mandevu			
21	Matero Main	X	X	
22	Matero Reference	X	X	
23	Mtendere	X	X	
24	Ng'ombe	X		X

24	NIPA			
26	Railway Clinic	X		X
27	Ridgeway			
28	Lilayi Clinic			
<b>Total</b>		<b>15</b>	<b>10</b>	<b>5</b>

## APPENDIX 8: CODING FRAMEWORK

Name	Code	Definition
1. Inspiration for public service	Security	Includes references to job security in the public sector
	Passion	Includes responses about passion/compassion/ heart for service as personal motivation for joining the public sector i.e working for a government clinic
Positive perceptions	PS+	Includes expression of positive sentiments of being in public service,
Negative perceptions	PS--	Includes negative expressions of being in public service
Change in initial perceptions	PS Change	Includes expressions about wanting to leave public service or changes in perceptions of public service as opposed to earlier motives
Initial perceptions maintained	PS Same	Includes statements that maintain similar inspirations/perceptions of public service as prior to joining
HCT Policy Experiences		
Knowledge of existence	Know.	Expressions of mere knowledge of the existence of the HCT guidelines
Knowledge of content	Know Cont.	Expressions of one's knowledge of the HCT guidelines and knows the content of the guidelines
Following of guidelines	Follow.	Includes expressions following the guidelines in the course of one's work
Ignoring guidelines	Ignore	Includes expressions of deliberate ignoring the guidelines despite knowledge of the content and/or existence
Positive perceptions about guidelines	PGuide--	Includes negative expressions on one's perception of the HCT guidelines

Negative perceptions about guidelines	PGuide++	Includes positive expressions on one's perception of the HCT guidelines
Environment	Overcrowd	Includes any reference to many numbers of people at the facility seeking HIV services
Busy	Busy	Includes general expressions on the how busy the clinic is in terms of demand vs supply, clients vs service providers
Heavy workload	workload	Includes expressions (mostly complaints) about workload of Counsellors
Challenges		
	Room	Any reference to limited physical space for Counsellors to do their work. Could include reference to multiple counselling sessions in one room or, lack of privacy
	Nursitude	Includes reference to negative or positive attitude from nurses to Counsellors, or from other professionals. Could also include language that talks about perceived behaviour of nurses after the introduction on Counsellors as a cadre.
	Stock-outs	Includes expressions of challenges that refers to stock-outs of testing kits and/or results slips
Coping Mechanisms		
Group Counselling	Grouping	Includes responses that talk about group counselling as a way of dealing with the constraints at the facility. May also include group counselling as a result of guidelines recommendations
	Rationing-T	Includes expressions that speak of cutting down time so that the Counsellor can attend to other clients
	Triage	Includes expressions of Counsellors using their discretion or judgment to choose who they see first based on the nature of the problem of that client